CURBSIDE INFUSION SERVICES

Fax To: (877) 428-1627
Email To: referrals@curbsideinfusion.com
Office: (877) 428-7248

ORDER FORM

☐ New Referral ☐ Hold ☐ Restart ☐ Medication/Order Change ☐ Benefits Verification Only

☐ D/C Infusion *(Medication(s) to D/C* _____*)*

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: ☐ MALE ☐ FEMALE
ADDRESS:	PHONE #:	
WEIGHT: ☐ LBS ☐ KG HEIGHT:	EMAIL:	
ALLERGIES:		

Please check that the following are included	☐ Patient demographics and insurance attached	☐ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	☐ Current Medication List	☐ G6PD
	☐ Baseline Uric Acid > 6.0mg/dl	

PHYSICIAN INFORMATION

Physician Name:	Email *(if you would like referral updates)*:
Practice Name:	Phone Number:
Office Contact:	Fax Number:

DIAGNOSIS

☐	☐	☐ Other:

ICD-10 CODE:	**Date of last infusion/injection:**

MEDICATION ORDERS

☐ _____

☐ Pre-medications
☐ Infusion will be administered per Curbside Infusion Venture policy and procedure.
☐ Other:_____

Notes/Comments

Physician Signature _____ **Date (Order is Valid for One Year)**_____

STANDING LAB ORDERS

☐ Labs to be Drawn by Infusion Center Frequency: _____ Every Infusion ☐ Other (*please specify*) _____

☐ CMP ☐ CBC ☐ CRP ☐ ESRP ☐ HFR ☐ UA

☑ In the event of anaphylaxis and infusion reaction, the infusion should be slowed, or stopped and restarted at a slower rate. Inform patient of signs and symptoms of anaphylaxis.

☑ Standing Analylaxis Protocol

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