



Fax To: 281-406-1047

Email To: referrals@curbsideinfusion.com

Office: 281-406-1046

ORDER FORM

<input type="checkbox"/> New Referral <input type="checkbox"/> Hold Renew <input type="checkbox"/> Restart <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> D/C Infusion (Medication(s) to D/C _____)
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PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS:	PHONE #:	
WEIGHT: _____ LBS _____ KG	HEIGHT:	EMAIL:
ALLERGIES:		
Please check that the following are included	<input type="checkbox"/> Patient demographics and insurance attached	<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List	<input type="checkbox"/> G6PD
	<input type="checkbox"/> 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

		<input type="checkbox"/> Other:

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

<input type="checkbox"/> Labs to be Drawn by Infusion Center	Frequency: <input type="checkbox"/> Every Infusion <input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> CRP <input type="checkbox"/> ESRP <input type="checkbox"/> HFR <input type="checkbox"/> 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.