General Drug Therapies

Provider Order Form Rev. 3.2023

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

***ICD 10 Code Required**

☐ ______________________, ICD10 __________ ☐ ______________________, ICD10 __________

INFUSION ORDERS

☐ Medication: ______________________

Dose: __________ ☐ mg ☐ gm ☐ _________

Route: ☐ IV ☐ SC ☐ IM ☐ Other ________________

Directions: ____

Duration of Therapy: __________ ☐ doses ☐ weeks ☐ months ☐ year

☐ Medication: ______________________

Dose: __________ ☐ mg ☐ gm ☐ _________

Route: ☐ IV ☐ SC ☐ IM ☐ Other ________________

Directions: ____

Duration of Therapy: __________ ☐ doses ☐ weeks ☐ months ☐ year

☐ Medication: ______________________

Dose: __________ ☐ mg ☐ gm ☐ _________

Route: ☐ IV ☐ SC ☐ IM ☐ Other ________________

Directions: ____

Duration of Therapy: __________ ☐ doses ☐ weeks ☐ months ☐ year

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: ______________________ Date of last treatment: ____________ Date of next treatment: ____________

OTHER ORDERS

LAB ORDERS: Labs to be drawn by**:** ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q __________ ☐ CMP q __________ ☐ CRP q __________ ☐ ESR q __________ ☐ LFTs q __________ ☐ Other: ________________

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

☐ Other: ____

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________________ Date: ______________

Physician Name: ______________ Provider NPI:______________ Specialty: ______________

Address: ______________________________ City/ST/Zip: ______________________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.