MEDICAL ASSOCIATES

Infusion Center
1500 Associates Drive • Dubuque, IA 52002
phone 563-584-4370 • fax 563-584-4232

# OUTSIDE INFUSION ORDER REQUEST

## PATIENT INFORMATION

Patient Name: _____ DOB: _____

Date of Last Infusion: _____

Date of Next Infusion: _____ ☐ N/A New Start

Height: _____ Weight: _____ GENDER: ☐ Male ☐ Female

Diagnosis (include ICD-10 codes): _____

Allergies: _____

**Please check to indicate the following *REQUIRED* documents have been attached:**

☐ Include completed and signed request form
☐ Patient demographics
☐ Current medication list
☐ Last office note supporting diagnosis
☐ Copies of insurance card (front/back)
☐ Prior Authorization for:
Medical Associates Clinic
NPI 1457300790
Tax ID 42-1115442

## ORDERS

**MEDICATION:** _____

**DOSE:** _____ **FREQUENCY:** _____

**ROUTE:** _____ **RATE:** _____

**DILUENT TYPE/VOLUME:** _____

**Patient Monitoring**

☐ Hold treatment and notify provider for: _____ ☐ Vitals per facility
☐ Monitor for _____ minutes after treatment prior to discharge ☐ Other: _____

**Pre-Medications**

☐ Tylenol PO dose: _____ ☐ Cetirizine PO dose: _____
☐ Loratadine PO dose: _____ ☐ Solu-Medrol IV dose: _____
☐ Dexamethasone IV dose: _____ ☐ Diphenhydramine PO dose: _____
☐ Other: _____

**Infusion Reaction/Anaphylaxis Order:**

☐ Per facility protocol
☐ Other: _____

**Additional Orders:** _____

_____

_____

ORDERS VALID FOR 1 YEAR FROM DATE SIGNED

## REFERRING PROVIDER INFORMATION

For questions regarding patient's care during the infusion, please contact:

Facility Name: _____ Fax: _____

Name 1st Point of Contact (must be available during infusion): _____

Phone: _____

Name 2nd Point of Contact (if 1st is unavailable during infusion): _____

Phone: _____

*By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon, that the referring specialist or delegate listed below will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.*

Ordering Provider Name (please print): _____

Ordering Provider Signature: _____

Date: _____