immersiv HEALTH

INFUSION ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ **ICD-10 CODE:** _____ **DESCRIPTION:** _____

☐ **ICD-10 CODE:** _____ **DESCRIPTION:** _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ Lab Results ☐ List of Medications ☐ Tried & Failed Therapies ☐ Most recent History & Physical

MEDICATION ORDER

MEDICATION: _____

DOSE/ROUTE: _____

FREQUENCY: _____

DURATION: _____

COMMENTS: _____

_____

LAB ORDERS

LAB: _____ FREQUENCY: _____

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg
☐ Cetirizine: 10 mg
☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg
☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

In the event of an adverse reaction occurring in the infusion suite, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN