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

Administer per protocol. 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