General Drug Therapies

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

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?

☐ Yes ☐ No

If yes, Facility Name: ____

Date of last treatment:__________________ Date of next treatment:__________________

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

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

☐ Other: ____

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: ________________

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.