HONORHEALTH

INFUSION Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Diagnosis:	**Diagnosis Code:** _____

Required Information	***Allergies:***		
	CBC, CMP (please include lab result documents)	Date:	Weight: Height:
	Applicable labs:	Date:	

Labs

- ☐ CBC, CMP every _____
- ☐ Other: _____

Pre-medications

- ☐ Diphenhydramine 25mg ☐ PO ☐ IV
- ☐ Diphenhydramine 50mg ☐ PO ☐ IV
- ☐ Methylprednisolone IV push 60mg
- ☐ Acetaminophen PO 325mg
- ☐ Acetaminophen PO 650mg
- ☐ Other:

Medication Order

(Drug, dose, route, frequency, and duration)

Drug: _____

Dose: _____ ☐ mg ☐ gm

Route: ☐ IV ☐ SQ ☐ IM

Frequency: Every _____

Duration: For _____

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.

Required Documentation

- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: