Patient Name
DOB
Cell Phone
Address

BLOOD TYPE & CROSS ORDERS

Diagnosis	☐ ICD 10 Code: ______ Other: ________________________
Labs	Hemoglobin: _________ Date: ___________ Hematocrit: __________ Date: ___________ Labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician If Infusion Clinic: __________________________
Premeds	☐ Acetaminophen 650mg PO once pre-infusion ☐ Diphenhydramine _____mg PO or IV once pre-infusion ☐ Methylprednisolone _______mg IV once pre-infusion ☐ Furosemide ______mg IV once, to be given in between units ☐ Other:______________________
IV Fluid	☐ NS TKO ☐ Other: __________________________
Blood Orders	☐ ______ units of Platelets ☐ ______ units of Packed Red Blood Cells (PRBCs) Irradiated ☐ Yes ☐ No CMV (-) ☐ Yes ☐ No
Additional Orders	
Monitoring	Monitor for signs/symptoms of hypersensitivity during infusion and 30 mins post-infusion. For any signs of infusion reaction: STOP infusion. Contact on-site provider for instruction.
Physician Information	Physician Name ______________________ NPI _____________ Office Contact ______________________ Phone _____________ **Provider Signature:** ______________________ Date _____________

REQUIRED DOCUMENTATION

o Patient Demographics & **Insurance** Information:	– Copy of patient's insurance card – front and back	FAX to (480) 400-6121
o **Clinical / Progress Notes**, supporting primary diagnosis:	– Most recent office notes	Intake Specialist (480) 927-3800
o Most Recent **Labs**:	– CMP and CBC	**referral@infuseablecare.com**