

Patient Information			
Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	
Additional Information Needed			
<input type="checkbox"/> Fax front/back of insurance card	<input type="checkbox"/> Fax clinical/progress notes	<input type="checkbox"/> Fax labs	
<input type="checkbox"/> Fax patient demographics	<input type="checkbox"/> Fax current medication list	<input type="checkbox"/> Fax TB and Hep B results	
Diagnosis and Clinical Information			
Diagnosis (ICD-10):			
<input type="checkbox"/> E86.0 Dehydration	<input type="checkbox"/> E87.8 Electrolyte and Fluid Imbalance		
<input type="checkbox"/> K52.29 Other Allergic and Dietetic Gastroenteritis and Colitis	<input type="checkbox"/> O21.0 Mild Hyperemesis Gravidarum		
<input type="checkbox"/> R11.2 Nausea with Vomiting, Unspecified			
<input type="checkbox"/> Other: Code: _____ Description: _____			
Clinical Information:			
<input type="checkbox"/> New Therapy Induction <input type="checkbox"/> Therapy Change <input type="checkbox"/> Therapy Continuation			
<input type="checkbox"/> Patient Weight: _____ lbs / _____ kg <input type="checkbox"/> Patient Height: _____ in / _____ cm			
<input type="checkbox"/> Allergies: _____			
<input type="checkbox"/> Therapies Tried and Failed: _____			
<input type="checkbox"/> TB Test: Date: _____ Results: _____ <input type="checkbox"/> Hep B Test: Date: _____ Results: _____			
Lab Orders			Lab Orders to be done by
<input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> ESR <input type="checkbox"/> CRP			<input type="checkbox"/> Oklahoma Infusion Services <input type="checkbox"/> Referring Provider
<input type="checkbox"/> Other: _____			
Prescription Information			
<input type="checkbox"/> Zofran IV	Dose: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg	<input type="checkbox"/> Frequency: every _____	
<input type="checkbox"/> Reglan IV	Dose: <input type="checkbox"/> 10mg	<input type="checkbox"/> Frequency: every _____	
<input type="checkbox"/> Pepcid IV	Dose: <input type="checkbox"/> 20mg	<input type="checkbox"/> Frequency: every _____	
<input type="checkbox"/> Other	<input type="checkbox"/> Medication: _____	<input type="checkbox"/> Dose: _____	<input type="checkbox"/> Frequency: _____
Pre-Medication Orders			
<input checked="" type="checkbox"/> Solu-Cortef 50-100mg SIVP		<input checked="" type="checkbox"/> Benadryl 25mg PO PRN	
<input checked="" type="checkbox"/> Tylenol tablet 500-1000mg PO PRN		<input type="checkbox"/> Other: _____	
Standing Orders for Adverse Reactions			
<input checked="" type="checkbox"/> Stop infusion and initiate NS bolus		<input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis	
<input checked="" type="checkbox"/> Notify supervising physician and ordering provider		<input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula	
<input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction		<input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness	
<input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation		<input type="checkbox"/> Other: _____	
Prescriber Information			
Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:
_____ Prescriber's Signature:		_____ Date:	
<p><i>By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.</i></p>			