LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

Diagnosis:
☐ ICD 10 Code:
☐ _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider ☐ Patient demographics AND insurance information ☐ Prior authorization with reference number	☐ Clinical/Progress notes (must be within 1 year) ☐ Labs and tests supporting primary diagnosis Pt may be required to submit a pregnancy test prior to treatment

List of tried and failed therapies, including duration of treatment:
1) _____
2) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____

Dosing	Please indicate Medication, dose, route and frequency ☐

Duration: ☐ x6 months ☐ x 1 year ☐ x _____ doses

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen _____ mg PO PRN
☐ Benadryl _____mg PO or IV
☐ Other: _____

☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Other: _____ Date:_____

ADDITIONAL ORDERS/INFORMATION

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS –