

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION			
Name:		DOB:	
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
DIAGNOSIS AND ICDE 10 CODE			
<input type="checkbox"/> HR + Breast Cancer		ICD 10 Code: C50.919	
<input type="checkbox"/> Prostate Cancer		ICD 10 Code: C61	
<input type="checkbox"/> Endometriosis		ICD 10 Code: N81.9	
<input type="checkbox"/> Other: _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> labs and tests supporting primary diagnosis	
List of tried and failed therapies, including duration of treatment:			
1) _____			
2) _____			
MEDICATION ORDERS			
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders			
Dosing	Drug/Dose	Route	Days to be given
	Please indicate frequency in blank space provided <input type="checkbox"/> Goserelin (Zoladex) 3.6 mg* <input type="checkbox"/> Gosereline (Zoladex) 10.8mg <input type="checkbox"/> Other: _____	SubQ implanted spring loaded injection _____	Every 4 weeks Every 12 weeks _____
*See instruction on how to administer in the abdomen only			
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses			
PREMEDICATIONS/ LAB ORDERS			
<input type="checkbox"/> Acetaminophen _____ mg PO PRN <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> Methylprednisolone _____ slow IV push <input type="checkbox"/> Other: _____		<input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> 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 – GOSERELIN (ZOLADEX)