Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

IV Hydration (Adult)

Patient Name: _____ Patient DOB _____

General

☐ Diagnosis- _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP every 30 minutes during the infusion and prior to discharge

IV Hydration Orders

Normal Saline (0.9% NaCl) bolus
☐ *500 mL, IV Bolus, Once*
☐ *1,000 mL, IV Bolus, Once*

Lactated ringer's bolus
☐ *500 mL, IV Bolus, Once*
☐ *1,000 mL, IV Bolus, Once*

Half Normal Saline (0.45% NaCl) bolus
☐ *500 mL, IV Bolus, Once*
☐ *1,000 mL, IV Bolus, Once*

Infusion Rate
☐ 999 ml per hour
☐ Other _____

Medications

Zofran (ondansetron)
☐ *2 mg, IV, every 4 hr, PRN nausea*
☐ *4 mg, IV, every 4 hr, PRN nausea*

Compazine (Prochlorperazine)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

IV Hydration (Adult)

☐ *5 mg, IV, Once, PRN nausea*
☐ *10 mg, IV, Once, PRN nausea*

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

☐ Biosimilar Substitution **NOT** permitted