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

Corticosteroid Treatment Plan

Patient Name: ______________________________ **Patient DOB** _________________________

General

☐ Diagnosis- ____________ ICD-10 Code _____________

Pt. Weight ___________ Pt Height ___________ Known Allergies ___________

Requested Start Date ____/____/_______

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_______

Authorized Treatment Duration ☐ Infuse Once ☐ Administer every ______ days for ________ doses

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 and prior to discharge

<u>Medications</u>

SOLU-Medrol

☐ *10 mg/kg, IV Piggyback, Powder-Inj, Day of Tx* ***[Less Than 100 kg]***

Comments: In NS 100 mL. For doses < 500 mg infuse over 30 minutes. For doses >= 500 mg infuse over 1 hour. Max dose = 1000 mg

☐ *1,000 mg, IV Piggyback, Powder-Inj, Day of Tx* ***[Fixed dose or 100 kg and over]***

Comments: In NS 100 mL. For doses < 500 mg infuse over 30 minutes. For doses >= 500 mg infuse over 1 hour. Max dose = 1000 mg

☐ *__________mg IV Piggyback, Powder-Inj, Day of Tx (OTHER)*

Comments: In NS 100 mL. For doses < 500 mg infuse over 30 minutes. For doses >= 500 mg infuse over 1 hour. Max dose = 1000 mg

Decadron

☐ *1 mg/kg, IV Piggyback, Injection, Day of Tx* ***[Less Than 100 kg]***

Comments: In NS 100 mL over 30 minutes. Max dose = 100 mg

☐ *100 mg, IV Piggyback, Injection, Day of Tx* ***[Fixed dose or 100 kg and over]***

Comments: In NS 100 mL over 30 minutes. Max dose = 100 mg

☐ *__________mg IV Piggyback, Injection, Day of Tx (OTHER)*

Comments: In NS 100 mL over 30 minutes. Max dose = 100 mg

☑ Notify Provider (Month 1 to 12)

Notify provider for temperature > 99.5 or HR < 55 or > 140, drop or rise in SBP more than 20 mm Hg from baseline

☑ 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_____________