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

Requested Treatment- Ambulatory Infusion

*Please note: This treatment plan should **ONLY** be used when a pre-built treatment plan for the medication being requested does not exist. Outpatient Infusion Services (OIS) staff have done their best to include all necessary information on this form, but information requests may be required based on the medication being requested.

General

Diagnosis ______________________ Diagnosis Code ICD-10)_________________________

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 medication every _____ weeks for ______ doses
☐ Other (please provide specific infusion instrucitons) ____
____
____

Infusion Monitoring

☑ Vital Signs
every 30 min, Prior to infusion, every 30 minutes during infusion, and prior to discharge
Pre-Medications - Administer 30 minutes before infusion is scheduled to begin

Pre-Medications

Tylenol
☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Benadryl
☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose
☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

SOLU-Medrol
☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose
☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

Treatment

Brand Name______________________ Generic Name _____________________ Dose: ___________________

☑ Pharmacy to determine appropriate / compatible base fluid and infusion rate as applicable.

- *Example- Medication to be infused in 250 mL normal saline over 30 minutes. Following infusion, flush with 30 mL of sterile 0.9% sodium chloride injection. Monitor for hypersensitivity reactions*

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ___________________________ Provider Name (please print)___________________________

Date_____/_____/__________ Patient Name ______________________________ Patient DOB________________

Requested Treatment- Ambulatory Infusion

☑ Communication Order

Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician

☑ Notify Provider

for Fever/Chills, chest pain, hypotension, hypertension, dyspnea, pruritis, urticarial, persistent flushing, Temperature > 100 or HR <50 or > 130

☑ INF Infusion Room Orders Subphase (Day 0, 14, 28)

☐ heparin flush 100 units/mL intravenous solution (Day 0, 14, 28)

5 mL, Intracatheter, Injection, Once, PRN other (see comment)

Comments: To maintain central line patency for implanted ports, flush once monthly or prior to deaccess

Lab Monitoring

Please list any corresponding labs to be completed and corresponding instructions:

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____

____

____

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Referring Provider. Please note that any request for infusion outside of standard treatment plans must be reviewed by the Medical Director of the respective infusion center for approval prior to patient scheduling. The Outpatient Infusion Services (OIS) team will do our best to have requested treatment plans reviewed within 48-72 hours, however additional time may be required based on patient complexity, new medication builds, etc. Please include information below where approvals, denials, or additional information should be directed.

Referring Office Contact Name (Please Print) ______________________________

Office Contact Phone Number (______) - ______ - _________________

Office Contact Fax Number (______) - ______ - _________________

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _________________________ Provider Name (please print)_________________________

Date_____/_____/__________ Patient Name ____________________________ Patient DOB_______________

☐ Biosimilar Substitution **NOT** permitted