*Chicago Illinois*
4711 Golf Road
Suite 900
Skokie, IL 60076

ThrIVewell INFUSION

Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

*Date:* _____

# INFUSION/INJECTION orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

○ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

## DIAGNOSIS *Please provide ICD-10 code*

☐ _____ _____
*(ICD-10)* *(description)*

☐ _____ _____
*(ICD-10)* *(description)*

## PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____

- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

## ORDERS

## NOTES

_____

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____