

Date: _____

INFUSION/INJECTION orders

Patient Name _____ DOB _____

Phone _____
Allergies M F

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 _____