



option care health®

INFUSION CLINIC PRESCRIBER ORDER FORM: TENNESSEE

| | | |
|--|-------------------------------------|--------------------------------|
| Clinical Hours of Operation Vary by Location Intake team available Mon-Fri 7:30am-6pm | REFERRAL PHONE | REFERRAL FAX |
| | Clarksville/Nashville: 615.726.0776 | 713.983.4647 (CAT Central Fax) |
| | Chattanooga: 800.775.5484 | 865.602.4202 |
| | Memphis: 888.211.0637 | 901.383.6566 |

| REFERRAL STATUS | TENNESSEE LOCATION |
|--|---|
| <input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal | <input type="checkbox"/> Chattanooga <input type="checkbox"/> Clarksville <input type="checkbox"/> Memphis <input type="checkbox"/> Nashville |

PATIENT INFORMATION

| | | |
|--|--|--|
| PATIENT NAME: | DOB: | SEX: <input type="checkbox"/> M <input type="checkbox"/> F |
| WEIGHT: <input type="checkbox"/> LBS <input type="checkbox"/> KG | PHONE NUMBER: | |
| ALLERGIES: | EMAIL: | |
| Please check that the following are included: | <input type="checkbox"/> Patient demographics and insurance attached | |
| | <input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached | |
| <input type="checkbox"/> Current Medication List: | | |

DIAGNOSIS

| | | |
|--------------|--------|----------------------------------|
| ICD-10 CODE: | OTHER: | DATE OF LAST INFUSION/INJECTION: |
|--------------|--------|----------------------------------|

PHYSICIAN INFORMATION

| | |
|-----------------|---------------|
| PHYSICIAN NAME: | PHONE NUMBER: |
| PRACTICE NAME: | FAX NUMBER: |
| OFFICE CONTACT: | |

MEDICATION ORDER

| | | | |
|-------------|---------|------------|-----------------|
| MEDICATION: | DOSING: | FREQUENCY: | NOTES/COMMENTS: |
| | | | |

| | |
|---------------------------|--|
| PHYSICIAN SIGNATURE _____ | DATE (Order is Valid for One Year) _____ |
|---------------------------|--|

LAB ORDERS

| | | | | |
|--|------------------------------|------------------------------|--|--------------------------------------|
| <input type="checkbox"/> CMP | <input type="checkbox"/> CBC | <input type="checkbox"/> CRP | <input type="checkbox"/> ESR | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Labs to be Drawn by Infusion Center | | Frequency _____ | Standing Order? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

TYPES OF ACCESS

| | | | | | |
|-------------------------------------|-------------------------------|----------------------------------|-------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Peripheral | <input type="checkbox"/> PICC | <input type="checkbox"/> Midline | <input type="checkbox"/> Port | <input type="checkbox"/> Subcutaneous | <input type="checkbox"/> Intramuscular |
|-------------------------------------|-------------------------------|----------------------------------|-------------------------------|---------------------------------------|--|