COMMUNITY HEALTH INTERVENTIONS SPECIALTY CLINIC

Community Health Interventions Specialty Clinic

INFUSION ORDERS- MISCELLANEOUS

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE
Diagnosis: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information	☐ Clinical/Progress notes supporting primary diagnosis ☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS
Please indicate medication, dose, route, and frequency: _____ _____
Refills: ☐ X 6 months ☐ X 1 year ☐ _____doses

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: jeff@eastoninfusion.com or call 728-777-5546

Fax completed form and all documentation to **(561) 709-8626**

All information contained in this form is strictly confidential and will become part of the patient's medical record.