PUREONE INFUSION

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New Referral **Dose or Frequency Change** **Order Renewal** **Resume Medication**

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Allergies: _____ Weight:(lbs) _____ Height: _____

Phone: _____ Email: _____

ICD CODE/ICD DESCRIPTION

Primary Diagnosis: _____ Secondary Diagnosis: _____

Other: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider NPI: _____

Phone: _____ Fax: _____

Practice Site Name: _____

Practice Address: _____

REQUIRED DOCUMENTATION

- This order is signed by provider
- Patient's demographics AND insurance information
- Clinical/progress notes supporting primary diagnosis
- Labs and tests supporting primary diagnosis

Tried and failed therapies: _____

MEDICATION ORDERS

Drug Name: _____

Dose: _____

Route: _____

Frequency: _____

Pre-Medications

- ◯ Acetaminophen: 500mg PO **OR** 650 mg PO, given 30-60 minutes prior to infusion/injection
- ◯ Benadryl: 25 mg / 50mg PO **OR** 25mg /50mg IV, given 30-60 minutes prior to infusion/injection
- ◯ Methylprednisolone: 100mg IV slow push, 30 minutes prior to infusion
- ◯ Other: _____

Refills: x6 months x1 year x____ doses

***Order valid x1 year unless indicated**

Special Instructions

_____

_____ _____ ____ /____ /____

Provider Name Provider Signature Date