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MEDICATION ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ GENDER: M F
 Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
 Email: _____
 Height: _____ in cm Weight: _____ lbs kg
 NKDA Allergies:

ORDER STATUS

New Referral Continuation of care Dose or frequency change Order renewal Other _____

DIAGNOSIS AND ICD 10 CODE

Diagnosis: _____ ICD 10 Code(s): _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____
 Provider NPI: _____ Phone: _____ Fax: _____

DOCUMENTS REQUESTED BY CIIC

History & Physical Most recent progress notes and lab results Medication list
 Additional Documents _____

Signed and completed order (Required)

MEDICATION ORDERS

Premedication/ Pre-hydration (if required):

<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg	PO	30-60 minutes prior
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> PO <input type="checkbox"/> IVP	30-60 minutes prior
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> 40mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Slow IVP	30-60 minutes prior
<input type="checkbox"/> Cetirizine HCl (Zyrtec)	<input type="checkbox"/> 10mg	PO	30-60 minutes prior
<input type="checkbox"/> Hydration needed	Diluent: _____	Volume: _____	Rate: _____
<input type="checkbox"/> Other: _____			

MEDICATION ORDERS: _____ **Ordered start date:** _____

Medication: _____ Generic substitution allowed
 Dose/ Route/ Frequency: _____
 Duration (end date): _____ Continue until directed
 Additional Orders : _____

CITRUS INFUSION AND INJECTION CENTER, INC. STANDING ORDERS:

Provide treatment under Citrus Infusion and Injection Center Inc.'s Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines and Action Plan for Infusion Reactions.

Provider Name _____ Provider Signature _____ Date _____