Outpatient Infusion Referral and Order Form

You may submit a face sheet from your organization in lieu of completing the Demographic and Financial Information below, provided all information requested is present. For questions please call (360) 346-2274.

PATIENT DEMOGRAPHIC INFORMATION:

Name: _____ Date of Birth _____

Address: _____ City, State, Zip:_____

Phone Number: _____

FINANCIAL INFORMATION:

Insurance:_____ Subscriber:_____

Policy#_____ Group#_____ Effective Date:_____

Service Authorization (phone) _____ (fax)_____

This Section for Internal use only:

Prior Authorization Required: Yes ❑ No ❑ Prior Authorization #:_____

Authorization Approval Date: ____/____/____ thru ____/ ____/ ____ J Code:_____

Applicable CPT Codes: _____ _____ _____

Additional Comments: _____

_____

_____

SUMMIT PACIFIC
• MEDICAL CENTER •
600 E Main
Elma, WA 98541

PATIENT LABEL (for internal use only)

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PATIENT CLINICAL INFORMATION:

Height: _____ Weight: _____ Kg or lbs (circle one)

Allergies: _____

Diagnosis/ICD10 Code: _____(orders without diagnosis codes will not be accepted)

☐ Include most current clinic note or labs that indicate medical necessity for medication/order.

MEDICATION/ORDER INFORMATION:

Order Date:_____ (Expires in 1 year OR # of doses_____)

Medication: _____ Dose:_____ Route:_____

Frequency:_____ If PRN, provide parameters:_____

IV Access:

- ☐ Peripheral IV, okay to leave in for 3 days? Yes ❑ No ❑
- ☐ PICC line insertion. Okay to use as midline if unable to place as PICC? Yes ❑ No ❑
- ☐ Access central line/port per RN discretion and SPMC protocol.

PREMEDICATION:

- ☐ Acetaminophen 650mg PO Once
- ☐ Diphenhydramine _____mg PO or IV Once
- ☐ Methylprednisone _____mg IV Once
- ☐ Other: _____

VITALS:

- ☐ Per SPMC Protocols
- ☐ Other: _____

LABS:

- ☐ CBC
- ☐ CMP
- ☐ ESR and CRP
- ☐ Hepatic Panel
- ☐ Other: _____

- ☐ Each Infusion
- ☐ Every _____

Fax results to: _____

PROVIDER INFORMATION:

Signature: _____ Name (print): _____

Date: _____ NPI#_____ Phone Number: _____

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