Newport Superior Infusion
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NEWPORTSUPERIOR
MEDICAL & INFUSION

Provider Order Form

Please fax the following documents along with referral to (949)484-4150

☐ Demographics ☐ Insurance
☐ Current Medications ☐ Relevant Patient Notes
☐ Current labs or recent lab results

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Height (in / cm): Weight (lbs / kg):

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable)

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip code:

LABORATORY ORDERS

☐ CBC w/ Differential ☐ every_____
☐ CMP ☐ every_____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ Other: _____
Other: _____
Other: _____

SPECIAL INSTRUCTIONS

_____

THERAPY ADMINISTRATION

Medication: _____

▪ Dose: _____

▪ Sig: _____

▪ Route: ☐ Intravenous ☐ Subcutaneous ☐ Other: _____

▪ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

Provider Name (Print)

Provider Signature

Date