MONTGOMERY KEETON
INFUSION CENTER

INTERNAL MEDICINE INFUSION ORDER FORM

P: 256-415-6542 F: 256-415-6415

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 2456-415-6415

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Infusion Orders
☐ Dehydration (ICD-10: _____) ☐ Gastroenteritis (ICD-10: _____) ☐ Other: _____ (ICD-10:_____)	1 Liter 2 Liters D5 0.45% NS IV x 1 1 Liter 2 Liters NS IV x 1 1 Liter 2 Liters LR IV x 1 ☐ May repeat dose x _____ days
☐ Iron Deficiency Anemia (ICD-10: _____) ☐ Iron Deficiency Anemia with CKD not on dialysis (ICD-10: _____) ****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****	☐ **Venofer** 200mg IV – Administer 5 doses over a 14-day period ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV (<50kg) – Give 2 doses at least 7 days apart ☐ **Injectafer** 750mg IV (>50kg) – Give 2 doses at least 7 days apart ☐ **Monoferric** 20mg/kg IV x 1 dose (<50kg) ☐ **Monoferric** 1000mg IV x 1 dose (>50kg)
☐ Nausea / Vomiting (ICD-10: _____)	☐ **Zofran** 4mg IVP 8mg IVP ☐ **Reglan** 10mg IV
☐ Pneumonia (ICD-10: _____)	☐ **Zithromax** 500mg IV daily x 3 days ☐ **Ivanz** 1mg IV daily x 7 days
☐ Chronic Sinusitis (ICD-10: _____)	☐ **Rocephin** 2gms IV daily x 14 days
☐ Chronic Bronchitis (ICD-10: _____)	☐ **Zithromax** 500mg IV daily x 3 days ☐ **Solu-Medrol** 125mg IVP x 1 day, then 62.5mg IVP x 2 days
☐ Pyelonephritis (ICD-10: _____) ☐ Complicated UTI (ICD-10: _____)	☐ **Rocephin** 2gm IV daily x 7 days ☐ **Ivanz** 1gm IV daily x 7 days
☐ Cellulitis/MSSA (ICD-10: _____) ☐ Location: _____	☐ **Rocephin** 1gm IV daily x 7 days
☐ MRSA (ICD-10: _____) ☐ Location: _____	☐ **Cubicin** 4mg/kg daily x 7 days **OR** 4mg/kg daily x _____ day(s) ☐ **Cubicin:** _____
☐ Multiple Sclerosis Exacerbation (ICD-10: _____)	☐ **Solu Medrol** 1gm IV daily for 3 days **OR** 5 days **OR** _____ days
☐ Migraines (ICD-10: _____)	**Zofran** 4mg IVP, may repeat x 1 **Zofran** 8mg IVP **Reglan** 10mg IV x 1 **Magnesium Sulfate** 1gm IV x 1 **Solu-Medrol** 125mg IVP x 1 **Depacon** 500mg IV x 1 **DHE 45** 1mg IV x 1 (must premed for nausea) **Toradol** 30mg IVP x 1 ☐ Repeat regimen x _____ days
☐ Other: _____ (ICD-10: _____)	☐ Other: _____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. MKIC will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.