Beebe Healthcare Outpatient Infusion Order Form

424 Savannah Rd. Lewes, DE 19958 Phone: 302-645-3300 Fax: 302-645-3624

Date: _____

Patient name: _____

Address: _____

DOB: _____Phone: _____

Insurance: _____

Height: _____ Weight: _____ Allergies: _____

Diagnosis Codes (ICD-10): _____

Pertinent Lab Values (provide copy): _____

Prescription order information (pre-medications or additional medications must be ordered separately-below):

Medication: _____
Route (IV, SC, IM): _____ Dose: _____

Frequency and Infusion Rate: _____

Total number of treatments: _____

Pre-Medication Order(s): Please select which medication(s) and write in the total dose for each patient.

- Diphenhydramine 25 mg oral tablet/capsule _____ mg once.
- Acetaminophen 325 mg oral tablet _____ mg once.

Provider Information:

Licensed Providers Name (printed): _____

Providers Signature: _____ Date: _____

Office Address: _____

Office Contact (printed): _____

Office Phone Number: _____ Office Fax: _____

***** Please include copies of patient's current lab results, H&P, and Current Medications*****