SOUTHWEST MEMORIAL INFUSION CLINIC

MEDICATION/LAB ORDER

PHONE: (970)564-2499 / FAX: (970)564-2498

PATIENT NAME: _____ DOB: _____WT: _____HT: _____PATIENT PHONE#: _____

MED ALLERGIES: _____PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

DIAGNOSIS: _____ ICD 10 CODE: _____ DATE TO BE DONE: _____

LAB ORDERS: _____

MEDICATION TO BE GIVEN: _____

_____

_____

J CODE: _____ CPT CODE: _____ RATE: _____ ROUTE: _____ DOSE: _____

FREQUENCY: _____ DURATION: _____

PRE-MEDICATIONS (IF NEEDED)

- ☐ TYLENOL 650MG PO
- ☐ BENADRYL 25MG PO OR IV
- ☐ BENADRYL SOMG PO OR IV

- ☐ OTHER: _____

TREATMENT FOR REACTION

For patient safety, we highly recommend completing this section,
In all cases we will immediately stop infusion and notify ordering provider.

- ☐ TYLENOL 650MG PO
- ☐ BENADRYL 25MG ____PO OR ___ IV
- ☐ BENADRYL 50MG ____ PO OR ___ IV
- ☐ OTHER: _____
- ☐ IF TYLENOL/BENADRYL IS NOT EFFECTIVE
- ☐ GIVE EPINEPHRINE (0.4MG) SUBQ
- ☐ SOLUMEDROL (12SMG) IV
- ☐ OXYGEN, BY NC IF SAT <90% OR S/S OF RESPIROTORY DISTRESS

PHYSICIAN NAME: _____ PHYSICIAN SIGNATURE: _____

DATE: _____