CommonSpirit

Infusion Therapy Order

Patient Name:_____ Date of Birth:_____

Address:_____ Height: _____ Weight: _____

Phone:_____ Allergies: _____

Primary Diagnosis:_____ ICD-10 Code:_____

Drug Name:_____

Requested Infusion Start Date:_____ Frequency:_____

Infusion Location:_____Duration:_____

Insurance Authorization: _____

Prescriber Information:

Prescriber Name:_____ NPI: _____

Address: _____

Phone: _____ Fax: _____

Prescriber Signature:_____

Please use a single line and mark through any orders you do not want if it is pre-checked…The Appointment request is required, but make edits to the Interval and Duration as needed…Please add any additional orders on the last page

SJH BLANK THERAPY PLAN

version 5/7/2024

Appointment Request

		Interval	Defer Until	Duration
☑	**SJH ONCBCN CHEMO THERAPY INFUSION APPOINTMENT REQUEST**	daily		5 days
☑	Infusion Appointment Request			

Appointment Request (continued)

	Interval	Defer Until	Duration

Status: Future, Expected: S Approximate, Expires: S+365, Sched. Duration: 30 minutes, Sched. Tolerance: Schedule appointment at most 0 days before or at most 0 days after

Nursing Communication

		Interval	Defer Until	Duration
☑	**SJH ONCBCN NURSE COMMUNICATION BLANK**			
☑	Nursing Communication	daily	S	5 days

IV fluids_____
Rate_____
Volume_____
Frequency_____
Duration of therapy_____