



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ _____
☐ _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

PRESCRIPTION

Pre-Medications

- | | |
|---|--|
| ☐ Acetaminophen: 650 mg PO | ☐ Acetaminophen: _____ mg PO |
| ☐ Cetirizine 10 mg PO | ☐ Famotidine: _____ mg IV |
| ☐ Dexamethasone: _____ mg IV | ☐ Loratadine 10 mg PO |
| ☐ Diphenhydramine: 25 mg PO | ☐ Methylprednisolone: _____ mg IV |
| ☐ Diphenhydramine: 25 mg IV | ☐ Ondansetron 4 mg IV |
| ☐ Other: _____ | |

Lab Orders

- ☐ CBC w/diff: every _____ ☐ weeks ☐ month
☐ CMP: every _____ ☐ weeks ☐ month
☐ Other: _____

Drug

**Oregon Specialty Infusion will determine appropriate product based upon benefit investigation*

- ☐ Medication to Order: _____
☐ Dose: _____
☐ Route: _____
☐ Frequency: _____
☐ Duration: _____

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No

If yes, please note therapy and last dose: _____

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI # _____ Specialty: _____

Office phone #: _____ Office Fax #: _____