

**Richmond**  
7110 Forest Ave, Suite 203  
Richmond, VA 23226



**Prince George**  
2025 Waterside Rd, Suite 100B  
Prince George, VA 23875

**Physician Order - General Order**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George

\* \* If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required \* \*

DIAGNOSIS AND ICD-10 CODE
<input type="checkbox"/> Diagnosis: _____ ICD10 _____

REQUIRED DOCUMENTATION (must include)
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information <input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Patient currently receiving same therapy at _____ Last dose: _____
List Tried & Failed Therapies, including duration of treatment
1) _____ 3) _____
2) _____ 4) _____

MEDICATION ORDERS
Please indicate medication, dose, route, frequency and duration of therapy (including max # of doses if applicable):
_____
_____
_____
Duration: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____

OPTIONAL PREMEDICATIONS and LAB ORDERS
<input type="checkbox"/> Acetaminophen 650mg PO prior to administration
<input type="checkbox"/> Diphenhydramine 25mg PO or IV (per patient preference) prior to administration
<input type="checkbox"/> Methylprednisolone 40mg slow IVP prior to administration
<input type="checkbox"/> Other PreMeds and Lab Orders with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:	Date:	

**Contact us with questions at: 804-442-3558 or email [referrals@theinfusionsolution.com](mailto:referrals@theinfusionsolution.com)**  
Fax completed form and ALL required documentation to 804-554-5848  
All information contained in this form is strictly confidential and will become part of the patient's record.