- [ ] New Prescription/Referral
- [ ] Prescription Refill

PRESCRIPTION(Rx)/REFERRAL

Rx:

Patient Name:	DOB:

MEDICATION/Strength:

ROUTE:

- [ ] Peripheral IV
- [ ] PICC
- [ ] Midline
- [ ] Port
- [ ] SubQ
- [ ] IM

Directions:

DIAGNOSIS:

ICD-10 CODE:

Pre-Medication:

- [ ] Solumedrol 125mg IVP
- [ ] Solu-Cortef _____mg IVP
- [ ] Tylenol ______mg PO
  - [ ] 650mg
  - [ ] 975mg
- [ ] Benadryl ______mg
  - [ ] 25mg
  - [ ] 50mg
  - [ ] IV
  - [ ] PO

ANA Kit Protocol:

- [ ] OK to use

Physician Signature	Date: (Valid for 1 year)

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Other:

Email:

Office Mailing Address:

Check that the following are included:

- [ ] Patient demographics & Insurance attached
- [ ] Clinical progress notes
- [ ] History and Physical
- [ ] Lab Results
- [ ] Other Test Results
- [ ] Diagnosis (supporting)
- [ ] Medication List