LOTUS HOUSTON HEALTH INFUSION SERVICES

FAX TO:877.643.0993

ORDER FORM

PATIENT INFORMATION

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

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

ICD 10 Code: _____

Description: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Please include lab results to support diagnosis.**

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: 125 mg SIVP
☐ Ondansetron: 4 mg ODT
☐ Ondansetron: 4 mg IVP
Other: _____
Other: _____

Lab Orders

Lab: _____ Frequency: _____
Lab: _____ Frequency: _____
Lab: _____ Frequency: _____

Medication to Order: _____

Dose: _____

Route: _____

Frequency: _____

Duration: _____

In the event of an adverse reaction occurring at a Lotus Houston Health location, utilize the Lotus Infusion adverse reaction protocol.

Comments: _____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____