Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____/_____/_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

IV Hydration (Adult)

Patient Name: _____ Patient DOB _____/_____/_____

General

☐ Diagnosis- _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Infusion (Month 1 to 12) Duration: 12 Months

☑ *Vital Signs (Month 1 to 12) BP/HR/Resp/SpO2/Temp*
Baseline on arrival to unit, upon completion of therapy, and prior to discharge

IV Hydration Orders

Normal Saline (0.9% NaCl) bolus

☐ *500 mL, IV Bolus, Every ____ Weeks for ____ treatments (max 3)*
☐ *1,000 mL, IV Bolus, Every ____ Weeks for ____ treatments (max 3)*

Lactated ringer's bolus

☐ *500 mL, IV Bolus, Every ____ Weeks for ____ treatments (max 3)*
☐ *1,000 mL, IV Bolus, Every ____ Weeks for ____ treatments (max 3)*

Half Normal Saline (0.45% NaCl) bolus

☐ *500 mL, IV Bolus, Every ____ Weeks for ____ treatments (max 3)*
☐ *1,000 mL, IV Bolus, Every ____ Weeks for ____ treatments (max 3)*

Infusion Rate

☐ 999 mL per hour
☐ Other _____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____
Date_____/_____/_____