PURE
INFUSION SUITES

GENERAL ORDER

**Fax form to:** 1-801-931-2631

*you must enter a 1 before the fax number*

## Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis:

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B results.**

*ICD 10 CODE

*** Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.**

☐ Drug

☐ Dose

Route: ☐ subcutaneous (SQ) ☐ IV

☐ Frequency

☐ Refills

Name of Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date/Time

Phone | Fax

Special needs/notes:

## INFUSION REACTION ORDER, CHOOSE ONE:

☐ Pure's Infusion Reaction Protocol

☐ Attached Infusion Reaction Protocol