


Infusion Associates
3230 Eagle Park NE, Suite101
Grand Rapids, MI 49525
616-954-0600 Phone
616-954-1675 Fax

IV ORDERS

****Please fax a copy of patient's Demographics, Current Lab Results, and Recent H&P****

Date: ____/____/____ Social Security # _____

Patient Name: _____ DOB: ____/____/____

Address _____

Phone Number(s) _____ Allergies: _____

Diagnosis & DX CODE (if known): _____ DX CODE: _____

Primary Insurance _____ Policy# _____

Secondary Insurance _____ Policy# _____

LABS to be drawn: **NONE**
CBC PT, PTT BMP CMP Urinalysis Other: _____
Weekly Monthly Other: _____

Fax Lab results to: # _____ ATTN: _____

Medication Order: _____

Drug / Route / Dose / Frequency / Duration

OR-----> **Pharmacist to Dose**

Start Date of Infusion: ____/____/____ End Date of Infusion: ____/____/____

Rx Expiration Date: ____/____/____

Other Orders:

Printed Doctor's Name: _____ Date: ____/____/____

Doctor Signature: _____

Name of office Contact / title _____

Phone# _____ Fax # _____