HealthQuest
Infusion & Specialty

GENERAL INFUSION FORM

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 **F** (832) 500-8629

LAST TREATMENT DATE: _____ NEXT DUE DATE: _____

☐ New Referral ☐ Updated Order ☐ Order Renewal

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____
Date of Birth _____ ☐ Male ☐ Female
E-mail _____

Prescriber's Name _____
Practice Name _____
NPI # _____ Office Contact _____
E-mail _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____
Allergies: ☐ Latex ☐ Other, specify _____
Diagnosis: _____ (ICD-10: _____)

REQUIRED DOCUMENTATION

☐ Patient demographics
☐ Insurance card/information
☐ Progress Notes/LABS supporting DX
☐ Medication list and H&P
☐ Letter of medical necessity if drug dosing or indication is outside of FDA Guidelines

THERAPY ORDER

Pre-medication orders: to be administered 15–30 minutes before infusion

☐ Acetaminophen 500mg PO
☐ Solu-Medrol _____ mg IVP
☐ Loratadine 10mg PO
☐ Normal Saline 500mL IV
☐ Diphenhydramine 25mg PO
☐ Diphenhydramine 25mg IV
☐ Cetirizine 10mg PO
☐ Quzyttir 10mg IVP
☐ Other: _____

Lab orders: ☐ CBC ☐ CMP ☐ CRP ☐ Other: _____

Lab frequency: ☐ Each infusion ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Anaphylactic Reaction Orders:

Epinephrine (based on patient weight)
>30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5–10 minutes x1
15–30kg (33–66lbs): Epinephrine 0.15mg IM or subQ; may repeat in 5–10 minutes x1

Diphenhydramine: Administer 25–50mg IV (adult) NS 0.9% 500mL IV bolus as needed (adult)
Refer to physician order or institutional protocol for pediatric dosing and infusion reaction management

Flush orders: NS 1–10mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____