Supporting documents for infusion order **FAX to 1 (888) 797-4008**

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? Yes No		

Order date:	Weight: kg lbs	Height: m in
Drug allergies: NKDA YES. Please specify.		

Please indicate documents in this transmission

Provider notes	Hematology	Chemistry/Serology	Imaging/Biopsy
☐ H&P	☐ CBC	☐ BMP/CMP	☐ Brain imaging
☐ Progress notes	☐ Coagulation studies	☐ Other chemistry	☐ EMG/NCV
☐ Other	☐ Other	☐ Serology	☐ Tissue biopsy
		☐ Viral titers	☐ Other
		☐ Other	

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.