REVITALIZE
INFUSION CENTER

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Previous infusion notes/records (if applicable)

Height: _____

Weight: _____

Intravenous Immune Globulin (IVIG) Orders:

☐ IVIG: May substitute brand based on product availability

☐ Do not substitute. Administer brand: _____

DOSE: ☐ IVIG_____ grams or _____gm/kg IV daily for _____day(s) or _____ week(s)

FREQUENCY: Every _____ weeks for _____ cycle(s)

☐ Other: _____

DURATION: ☐ 6 months ☐ 12 months ☐_____ Doses ☐ Other:_____

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg IV ☐ Methylprednisolone 125 mg IV

☐ Loratadine 10 mg PO ☐ Cetirizine 10 mg PO

☐ Other: _____

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus