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
- Relevant labs and tests
- Medication List

Height: _____

Weight: _____

Orders:

Drug: _____ **Dose:** _____ **Doses Authorized:**_____

Administration Instructions:

_____

_____

Pre-Medication Orders (Check the Requested Orders):

☐ Acetaminophen 650 mg PO ☐ Certirizine 10 mg PO ☐ Diphenhydramine 25 mg PO
☐ Diphenhydramine 50 mg IV ☐ Loratadine 10 mg PO ☐ Normal Saline (0.9%) _____ mL IV
☐ Solumedrol _____ mg IV ☐ Other: _____
☐ NONE (no premedications)

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