

**Infusion Center
Request for Services Form**

Referring Physician Name: _____ Phone: _____

Patient Name: _____ DOB: _____ SS # _____ (Optional)

Telephone Numbers: Home # _____ Alternate # _____

Patient Address: _____

New Patient Follow-Up Visit Urgent visit (please schedule as soon as possible)

<p>REQUEST FOR SERVICE (check all that apply):</p> <p><input type="checkbox"/> Blood product transfusion <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Bone Marrow Biopsy <input type="checkbox"/> Medication (other) <input type="checkbox"/> Port Flush <input type="checkbox"/> IV Hydration <input type="checkbox"/> PICC Line Insertion <input type="checkbox"/> IV Medication <input type="checkbox"/> Infusion (other) _____</p>	<p>Diagnosis: _____</p> <p><input type="checkbox"/> Anemia <input type="checkbox"/> Aplastic <input type="checkbox"/> Chemo induced <input type="checkbox"/> Due to CKD <input type="checkbox"/> Due to malignancy <input type="checkbox"/> Blood Loss <input type="checkbox"/> Chronic Disease</p> <p><input type="checkbox"/> Other Anemia type: _____</p> <p><input type="checkbox"/> Dehydration</p>	<p>Cancer Diagnosis</p> <p>_____</p> <p><input type="checkbox"/> Primary <input type="checkbox"/> Blood forming</p> <p>Metastatic Sites (<i>list all</i>)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Estimated Length of Time (Complete if known)

- 15 minutes 300 minutes (5 hours)
 30 minutes 360 minutes (6 hours)
 60 minutes (1 hour) 420 minutes (7 hours)
 120 minutes (2 hours) 480 minutes (8 hours)
 180 minutes (3 hours) Other (give brief description)
 240 minutes (4 hours)

Please Schedule Return Visit

- _____ Day (s)
 _____ Week (s)

Treatment Chair Patient requires private treatment room Reason: _____

Special Instructions _____

Patient will require transportation home with a responsible adult

Signature of individual completing this form

Date

Please fax the following additional information:

- Physician order sheet
- Signed consent form (blood product or chemotherapy)
- Photocopy of patient insurance information

Signature of UCH Infusion Center Team Member

Date

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