Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aacenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

SOLU-MEDROL ORDER FORM

(- Required Fields)*

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION		
NAME*:	DOB*:	SEX: M F
ADDRESS:	PHONE:	
WEIGHT: LBS KG / HEIGHT:	EMAIL:	
ALLERGIES:		

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

SOLU-MEDROL ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ________________________________

____ Dosing: ____

Frequency:____

Administration Time: ________________________________

Physician Signature* ______________________________

Date*(Order is Valid for One Year)____________________

Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Other__________________________

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P

Last Infusion/Injection Date: ____________________

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ______________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

-------Oklahoma-------

___ Tulsa

REVISION DATE- 05/2020