



## Generic Infusion Order Form

**Please include the following (required):**

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Allergies**

\_\_\_\_\_  
**weight**

\_\_\_\_\_  
**Patient Phone**

**Primary Diagnosis**

**Diagnosis and ICD-10 Code** \_\_\_\_\_

**Secondary Diagnosis**

**Diagnosis and ICD-10 Code** \_\_\_\_\_

### Prescription Orders:

Medication & Instructions: \_\_\_\_\_

Premeds: \_\_\_\_\_

**Refills:**  12 months     for \_\_\_\_\_ infusions

**I authorize NTIDC to use their protocol for reactions in the office.**

\_\_\_\_\_  
**Physician Name**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Fax**

\_\_\_\_\_  
**Physician's signature**

\_\_\_\_\_  
**Date**

**Fax completed form to (214) 887-0436. Contact us directly at: (214) 276-5642.  
Or visit us online at [www.ntinfusioncenters.com](http://www.ntinfusioncenters.com)**