TEXAS ONCOLOGY

SPECIALTY INFUSION THERAPY

PHYSICIAN INFUSION ORDERS

PATIENT INFORMATION

❑ Demographics Attached

Name: _____ DOB: _____ Phone #: _____

Insurance Information: Please attach copies of medical and prescription identification cards (front and back)

MEDICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____ Patient Weight: _____ lbs.

Allergies: _____

❑ Clinical Notes, Labs, and Test Results supporting primary diagnosis attached

LABS

Required labs to be drawn by: ❑ Infusion Clinic ❑ Referring Physician

Lab Orders _____

PHYSICIAN ORDERS

_____

_____

_____

_____

**Patient will be scheduled once all required documentation is received.

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Texas Oncology and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone#: _____ Fax #: _____

Contact Person: _____

Please submit this form via fax to 512-822-7591

Specialty Infusion Therapy is located at a Texas Oncology site near you.
Please call 512-982-3795 or visit TexasOncology.com for more information.

Texas Oncology Use

Appointment Date: _____

Time: _____

Patient Notified: _____

Referring Physician Notified: _____