



155 Crystal Run Road  
Middletown, NY 10941

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[www.crystalrunhealthcare.com](http://www.crystalrunhealthcare.com)

## FAX COVER SHEET

To: ORMC Infusion

From: Kim Hoeffner

Company:

To Fax Number: 3339400

Fax Reference ID: KHO5E3808A78BB8

Date: 2/3/2020 11:48:52 AM

# of pages [incl. cover]: 4

Notes/Comments:

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Middletown, NY 10941

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**FAX TRANSMISSION**

<b>Date</b> 02/03/2020	<b>Time:</b>	<b>From:</b> Crystal Run Healthcare
<b>Receiver's Name:</b> Infusion Inbound <b>Phone Front Desk:</b> 845-333-1150 <b>Stacy phone:</b> 845-333-1905 <b>Inbound Fax:</b> 845-333-9400		<b>Department:</b> Oncology - Monroe <b>Phone:</b> 845-615-6999 <b>Fax:</b> 845-703-6288

**Number of pages, including this coversheet:**

Information Transmitted: 3

Appointment Date Needed: when availableName of Patient: Lisa HicksDOB: 10/02/1975MRN #: 87063Diagnosis written on Order: Iron deficiency anemia

Authorization Number: \_\_\_\_\_

Thank you

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Preferred Provider:

PCP: Aruna Panini MD

Account Number: 000000134383

<b>PATIENT INFORMATION</b>			Date of Birth	Sex
Patient Name Lisa A Hicks			10/02/1975	F
Other Name Used		E-mail	Marital Status	Soc. Sec. #
		pigglets1975@yahoo.com	M	113-72-3886
Mailing Address		City	State	Zip
606 Finch Lane		Cuddebackville	NY	127295536
Employment			Home Phone	
<u>Employer Name</u>			<u>Occupation</u>	<u>Employer Phone</u>
			Homemaker	845-290-3220
			Business Phone	
Spouses Name				

<b>EMERGENCY CONTACT</b>		
Name	Relationship	Phone

<b>INSURANCE COVERAGE</b>	
Primary Insurance Company : MVP Medicaid/CHP/Essentials Spec.	
Secondary Insurance Company: MVP Medicaid/CHP/Essentials PCP	

ORANGE REGIONAL MEDICAL CENTER  
Physician Order Form

## DO NOT USE ABBREVIATIONS

U	MS	SC	QOD
IU	MSO <sub>4</sub>	SQ	Mg
QD	MgSO <sub>4</sub>	SL	

Lisa Hicks  
10/2/75

Addressograph

New Orders: (ENTER ORDER IN BLOCK SPACE PROVIDED. PHYSICIANS MUST SIGN EACH BLOCK OF ORDERS)

Iron deficiency anemia

Venofer 400mg IV weekly x 6 doses (six doses)

Print Last Name: A. MARBURNPhysician Signature: [Signature]Date: 11/31/20 Time: 12:30 PMPrint Last Name: A. MARBURN

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RBV INIT \_\_\_\_\_ Time: \_\_\_\_\_ Faxed ☐ Time Faxed \_\_\_\_\_

Print Last Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Last Name: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RBV INIT \_\_\_\_\_ TIME: \_\_\_\_\_ Faxed ☐ Time Faxed \_\_\_\_\_

\*\*Pharmacy is authorized to dispense generic equivalent unless noted otherwise.\*\*