Insurance Verification

Name: Morgan Escano DOB: 1/9/88 MR# 110230
Ins. ID # [illegible] EXL84308088
Phone#: 1800-992-2583 1866-493-0515 800-992-2583
Date: 9/26/17 Time: 12:37 DX: D64.9
Eff Date: [illegible] 1/1/17
Copay: 0 copay DED: 0
Percent: 100 % OOP: 0
Name of Person: Crystal
REF: 092617-006453
Jcode: J1756 | 96365

Auth Req'd YES: ________ NO: ✓ for either codes
Auth# ________ Date Span: ________
Phone: ________ Fax: ________
Name: ________

Can we Buy and Bill:
YES: ________ NO: ________
Specialty Pharmacy: ________
Phone#: ________ Fax: ________

IF STACY IS NOT HERE, YOU MUST FAX TO CHARLOTTE

OUTPATIENT INFUSION CENTER
ORANGE REGIONAL MEDICAL CENTER
NEW PATIENT INTAKE FORM
(MUST BE USED EVERYTIME A NEW PATIENT IS BOOKED)

to be Scheduled ASAP per Dr. Dinamore

NAME: Morgan Escano
DOB: 1/9/88
PT'S PHONE NUMBER: 845-313-9957
PROCEDURE: Venofer x5
DATE OF PROCEDURE:
DURATION: INFUSION 1 hour
DIAGNOSIS: Anemia, Pregnant
NAME OF PERSON TALKED TOO:
PHYSICIAN & PHONE: Dr. Dinamore 703-6999
INSURANCE: Empire BCBS
ALLERGIES: NKA

IMMEDIATELY AFTER MAKING THE APPOINTMENT FAX THIS FORM AND COPY OF THE SCRIPT FOR AUTHORIZATION AND PRE REGISTRATION PROCESS.

FAX ALL NEW CHEMO TO PHARMACY X 1124

NO IVIG, RITUXIAN, REMICADE BEFORE AUTHORIZATION.
AFFINITY IVIG HOME CARE ONLY

STACY BUDD:
PHONE: (845) 333-1482
FAX: (845) 333-1715

CHARLOTTE:
PHONE: (845) 294-9708 x 296
FAX: (845) 294-8340

Sep. 26. 2017 12:48PM

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

ESC No. No. 8172 P. 3N

1.9.88.

Patient Label

TO BE COMPLETED BY PHYSICIAN:	Patient Name:	DOB:
Date Written: 9/23/17	Date of Administration:	
Diagnosis: Iron Def. Anemia	TNM Stage:	Allergies: ☐ NKDA
Protocol / Regimen – Venofer	Cycle of Day	
Venous Access: ☐ Peripheral ☐ Central		

Height	Weight	Body Surface Area (m^2)	Emetic Level
ft in	kg ☐ Actual ☐ Ideal ☐ Adjusted ☐ Dosing		☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters:

ANC less than: WBC less than: PLT less than: Hgb/Hct less than: SCr greater than:

Non-chemotherapy orders:	RPh initials / Nurse initials	
☐ IV Fluids: NS @ KVO (20 mL/hr)		
LABS. CBC CMP FERRITIN, PTT, PT/INR		
Venofer 200 mg IV x 5 doses.		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed *(Rounding to be completed by RPh)*	Route	Infusion Rate	RPh / Nurse initials	

*If using a dose reduction, please provide rationale:

MD Name (Print) Dinsmore MD Signature [signature] Date/Time 9.23.17

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____