Crystal Run Healthcare
155 Crystal Run Road
Middletown, NY 10941
845•703•6999
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:

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road

Middletown, NY 10941

ORANGE REGIONAL MEDICAL CENTER

FAX TRANSMISSION

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

Number of pages, including this coversheet:
Information Transmitted: 3

Appointment Date Needed: when available

Name of Patient : Lisa Hicks

DOB: 10/02/1975

MRN # : 870163

Diagnosis written on Order: Iron deficiency anemia

Authorization Number : _____

Thank you

NextGen

Preferred Provider:

PCP: Aruna Panini MD

Account Number: 000000134383

PATIENT INFORMATION

Patient Name			Date of Birth	Sex
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	Home Phone
606 Finch Lane	Cuddebackville	NY	127295536	(845) 421-0340
Employment				Business Phone
Employer Name	Occupation		Employer Phone	
	Homemaker		845-290-3220	

Spouses Name

EMERGENCY CONTACT

Name	Relationship	Phone

INSURANCE COVERAGE

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_4	SQ	Mg
QD	$MgSO_4$	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 400 mg IV Q week x 6 doses (six doses)

Print Last Name A. MARBERRY
Physician Signature [signature]
Date 1/31/20 Time: 12:30 pm

Print Last Name: A. MARBERRY
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."