O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Miscellaneous Infusion Orders

At OSMS, we provide individualized care tailored to each patient's unique needs. If you require infusion care and do not see your specific medication listed, please complete our Miscellaneous Infusion Request Form. A member of our team will contact you within 5 business days to let you know whether we can accommodate your infusion service needs.

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION			
Date:	Patient Name:	DOB:	
☐ NKDA Allergies:		Weight:	
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:		Next Due Date:	
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE	**REQUIRED DOCUMENTATION**
☐ Other: _____ ICD 10 Code: _____	☐ This signed order form by the provider ☐ Patient demographics AND insurance information (copy of cards) ☐ Clinical/Progress notes ☐ Lab and Tests supporting primary diagnosis

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

PREMEDICATION ORDERS

☐ No premeds
☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg
☐ Diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)
☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg
☐ Fexofenadine (Allegra) PO ☐ 180mg

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)

Please indicate medication, dose, route, and frequency:

_____

_____

Refills: ☐ X6 months ☐ X1 year ☐ _____ doses

**Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.*

_____

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.