NEW YORK CANCER & BLOOD SPECIALISTS

Conquering Cancer Together™

Standard Medication Order Form

Provider Order: External Referring Partner

Patient Information:

Patient Name:_____ **DOB**:_____ **Today's Date:**_____

Diagnosis (ICD 10): _____ **Allergies**: _____

FOR NEW REFERRALS - Please fax the following to our STAT fax number 631-656-7005

1. Last Provider Note 2. Demographic Information 3. Insurance Cards 4. Photo ID 5. Lab Results

All patients will receive a phone call from our patient navigator to schedule treatment once authorization is obtained. Patients will establish care with a New York Cancer & Blood Specialists Provider in our infusion suite with their first treatment and will be evaluated at least once every 6 months or in the event of an adverse event with treatment. All associated lab results, provider note & medication administration records will be faxed to the contact number provider below within 7 days of treatment.

MEDICATION ORDER(S)

Height: _____ ***Weight:*** _____

	ROUTE	DOSE	Units	Duration (In minutes)	Frequency

The medication orders above are approved clinically, effective date: _____

[ ] 12 weeks [ ] 24 weeks [ ] 36 weeks [ ] 52 weeks **(Maximum)**

LAB ORDERS (n/a for those that do not apply)**:**

STAT with result PRIOR to Administration: _____ **With Administration:** _____

Following administration: _____

Standard Treatment Parameters for Chemotherapy/Immunotherapy: *If the patient is symptomatic, reports acute symptoms and/or does not meet standard treatment parameters outlined; they will be seen for evaluation the same day.*

Lab Value	Standard Value *(asymptomatic)*	Adjusted Value *(if blank follow standard)*	Additional Comments/ Requirements
Hemoglobin	>or = 10		
White Blood Cell	> or = 1.5		
Absolute Neutrophil Count	> or = 1.0		
Platelets	> or = 100		**Provider Initials:**

Print HCP Full Name: _____

HCP Signature:_____ **Date:**_____

Direct Telephone Contact Number: _____