

ELOXATIN (oxaliplatin) Referral Order Form



WWW.PACEINFUSION.COM

PH: 330-625-4900

F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change (New Order Rqd.) ☐ Verify Benefits Only ☐ D/C Infusions *indicate name of drug(s)

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____

Phone # _____

Email: _____

Insurance ID #: _____

PRESCRIBER INFORMATION

Referring Physician: _____

Address: _____

Office Contact: _____

Phone # & Ext.: _____ Fax #: _____

Direct Message _____

Address _____

ELOXATIN MEDICATION ORDERS

Patient Information: kg _____ m2 Dosing: _____ mg/m2 IV every _____ weeks

DIAGNOSIS/INDICATION

- ☐ Advanced colorectal cancer
☐ Stage III colon rectal cancer
☐ Antiemetics _____
☐ Other _____

NOTES (ADDITIONAL INFO)

*ICD-10 _____ required

Ordering Provider's Signature

Date

REQUIRED DOCUMENTATION

- ☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

PLEASE ATTACH THE FOLLOWING REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ☐ AST / ALT / bilirubin / creatinine
☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY