ELOXATIN (oxaliplatin) Referral Order Form FAX (877) 637-6691

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)* ____________

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

PATIENT INFORMATION

Name: ____________________ Date: __________

DOB: ______________ SS# ______________

Phone # ______________

Email: ______________________________

PHYSICIAN INFORMATION

Referring Physician: ______________________________

Practice Address: ______________________________

____

Office Contact: ______________________________

Contact Phone # __________ Contact Fax # __________

NPI / TIN: ______________ ______________

ELOXATIN MEDICATION ORDERS

Patient Information: ____ kg ____ m2 Dosing: ______ mg/m2 IV every _____ weeks Refills: ____________

INDICATION/DIAGNOSIS

☐ Advanced colorectal cancer
☐ Stage III colon rectal cancer
☐ Antiemetics ______________
☐ Other ______________

***ICD-10 ____________________ required**

NOTES (ADDITIONAL INFO)

______________________________ __________
Referring Physician'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

ATTACH 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