TAXOTERE (docetaxel) Referral Order Form

FAX (877) 637-6691

VASCO INFUSION
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: _____ _____

TAXOTERE MEDICATION ORDERS

Patient Weight:_____ kg Dosing: _____mg IV every _____ weeks Refills: _____

Premeds: ☐ dexamethasone 16mg/day for 3 days, start 1 day prior to infusion ☐ Other _____
☐ dexamethasone 8mg @12 hrs, 3 hrs and 1 hour before infusion

INDICATION/DIAGNOSIS

- ☐ Breast cancer
- ☐ Non-small cell lung cancer
- ☐ Hormone refractory prostate cancer
- ☐ Gastric adenocarcinoma
- ☐ Squamous cell carcinoma of the head/neck cancer

***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)

☐ PPD Results (w/in 12 months)

☐ Comprehensive Metabolic Panel, CBC with differential

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY