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: _____

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

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