

# RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

## Dalvance Referral Order Form

### Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

### Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

### Dalvance Medication Orders

Dosage <ul style="list-style-type: none"><li>• ____ 1.5 grams IV once</li><li>• ____ Other _____</li></ul> Patient Weight: ____ Lbs or ____ Kg	
Diagnosis with ICD 10 code <b>(REQUIRED)</b> <ul style="list-style-type: none"><li>• Diagnosis: ____ Skin and soft tissue infection ____ Other _____</li><li>• ICD 10 code _____</li></ul>	
Pre-Medication <ul style="list-style-type: none"><li>• Tylenol ____ mg • Benadryl ____ mg __ IV or __ PO</li><li>• Solumedrol IV Push ____ mg • Other _____</li></ul>	Refills <ul style="list-style-type: none"><li>• Zero ____ • Treatments for 1 year _____</li><li>• Other _____</li></ul>

### Required Documentation

<input type="checkbox"/> Insurance Cards (Front and Back)	<input type="checkbox"/> Patient Demographics <input type="checkbox"/> Lab Results – CMP, CBC	<input type="checkbox"/> Recent Progress Notes
<b>Special Instructions/Notes</b>		

\_\_\_\_\_  
Prescribing Provider Signature

\_\_\_\_\_  
Date of Signature