NCH north country healthcare | Androscoggin Valley Hospital

Patient Name:
DOB:
Address:
Cellphone:

AVH Infusion Center P 603-326-5782 F 603-326-5971
Monday - Friday 8am-4pm

General Order Sheet

Please send copy of Prior Authorization with this form, if required

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Status ☐ New Therapy ☐ Order Renewal ☐ Dosage or Frequency Change

Diagnosis ☐ ICD 10 Code: _____ _____
☐ ICD 10 Code: _____ _____

Order ☐ _____
Biosimilar, generic or insurance preferred, okay? YES or NO (circle one)

Dosage Dose: _____

Route: _____

Patients Height: _____ inches

Patients Weight: _____ lbs or kg (circle one)

For weight-based dosing (when applicable):

If weight changes +/- 10% from initial treatment weight, adjust dose? YES or NO (circle one)

Frequency _____

Premeds ☐ No premeds necessary
☐ Other: _____
_____

Labs (What and when): _____
Provide results to: _____ Fax: _____
☐ N/A

Other Considerations **(Monitoring, rate, etc)**
_____
_____

Ordering provider _____ **Office Number** _____

Provider signature _____ **Date** _____

NCH provider co-signature (if required): _____ **Date** _____

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REQUIRED DOCUMENTATION

FAX to (603)-326-5971

Clinical / Progress Notes, supporting primary diagnosis: (AVH to validate necessity of IV treatment)
- Chart Summary
- Medication/Allergy List

Most Recent **Labs**:
- Labs pertinent to therapy ordered

Prior Authorization: (when required)
-Services cannot be scheduled until a valid prior authorization is obtained by the ordering provider