Donayre Cancer Care Center
Columbus Regional Healthcare System

MEMBER

Atrium Health
Levine Cancer

To all providers,

Beginning October 1, 2023, use the attached new Outpatient Treatment Order Sheet for antibiotics, fluids, injections etc. and follow the instructions below to ensure timely scheduling of outpatient treatments.

1. **Complete all information on the Order sheet**. Orders missing information will be returned.
   - Patient demographics
     - Name and address
     - Date of birth
     - Height, weight, and allergies
   - Diagnosis
     - Diagnosis and Diagnosis Code
     - Prior Auth approval number.
   - Medications Ordered
     - Name of medication
     - Dose
     - route
     - Infusion rate for IV route
     - frequency
     - duration of treatment
   - Provider information
     - PRINTED name
     - Phone and fax number
     - NPI number
     - Signature with Date and Time
2. **Fax completed order to the Main Pharmacy at CRHS, 910-642-1730, and to DCCC, 910-641-8226. Call DCCC 910-641-8220 option 3 to verify order has been received.**

3. **DCCC will call the patient to schedule an appointment. NO WALK-INS ALLOWED.**

**Patients must be able to ambulate and capable of self-care to receive outpatient treatment at DCCC.*

Unstable patients or need for urgent treatment should be sent to ED for evaluation and treatment.

Thank you for helping us provide the safest care possible for your patient.

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Columbus Regional Healthcare System

Patient Sticker:

MEMBER

Atrium Health Levine Cancer

Start Date:_____
Stop Date:_____

Phone:910-641-8220 Fax 910-641-8226

OUTPATIENT TREATMENT ORDER SET

PATIENT DEMOGRAPHICS:

Patient Name:_____ Date of Birth_____

Address:_____

City, State, Zip_____

Height_____ CM Weight_____KG

Allergies:_____

Diagnosis and Diagnosis Code: _____

Prior Authorization Approval Number:_____

MEDICATION ORDERS:

Medication:_____ _____

Dose _____ To infuse over_____minutes

To be given:_____ Subcutaneously _____Intramuscularly _____IV Push

_____Perform a post infusion monitoring period of _____minutes.

FREQUENCY:_____

DURATION:_____1 TIME _____WEEKS _____MONTHS _____OTHER_____

SPECIAL ORDERS:_____

LINE USE:_____May access and use PICC/CVC and flush per policy.

PROVIDER INFORMATION:

PRINTED PROVIDER NAME:_____

PHONE:_____ FAX:_____

PROVIDER NPI:_____

PROVIDER SIGNATURE:_____

DATE/TIME:_____

ALL SECTIONS MUST BE COMPLETED BEFORE PATIENT WILL BE SCHEDULED

FAX COPY OF ORDER TO MAIN PHARMACY AT 910-642-1730 AND DCCC AT 910-641-8226

WE WILL CONTACT PATIENT TO SCHEDULE AN APPOINTMENT FOR TREATMENT

NO WALK-INS ALLOWED