Lewis County Health System

7785 North State Street
Lowville, New York 13367
Phone 315-376-5200
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www.lcgh.net

CONFIDENTIAL

DATE: ____________________

PLEASE DELIVER TO: **Lewis County Health System – ASU Department**

FAX #: **315-376-0130**

COMPANY: ____________________

FROM: ____________________

NUMBER OF PAGES (INCLUDING COVER SHEET): ____

SUBJECT: **INFUSION REQUEST**

NOTES: ____________________

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Lewis County Health System
Your Health Partner

Cover Sheet

OUTPATIENT SERVICES REQUEST CHECKLIST

What is needed to schedule your patient for treatment at Lewis County General Hospital

Patient Name ____________ **DOB** ____________ **Gender** ____________ **Patient Phone #** ____________

Please attach separate order form for Infusion or procedure (i.e., wound care)

____

Diagnosis/Indications for treatment:

____

Please ensure the following are attached:

- ☐ **Authorization / Insurance approval completed**

  Reference # ____________ Date ____________

  Authorization # ____________ Date ____________ Expiration Date ____________

- ☐ **Patient Demographic Cover Sheet**
- ☐ **LCGH specific Order Sheet completed in full?**
  - ☐ Patient's name
  - ☐ Patient's DOB
  - ☐ Diagnosis
  - ☐ Signed, dated, and timed by ordering physician
  - ☐ Allergies
- ☐ **Consent completed** (for blood products including IVIG)
- ☐ **H&P or initial treatment and annually thereafter to include (at a minimum) – patient age, diagnosis, problem list, medication list, physical exam, and purpose for drug.**
- ☐ **Print and fax to LCGH Ambulatory Outpatient Department**

Please make sure **ALL boxes are checked prior to faxing to LCGH ASU
Upon completion, scheduling will be done by LCGH

Provider (or designee) Print Name ____________ **Phone #** ____________ **Fax #** ____________

Provider (or designee's) Signature ____________ **Date** ____________

Fax completed form to: 315-376-0130 / Contact us directly at: 315-376-5233 / Visit us online at: lcgh.net

Lewis County
Health System

DOCTOR'S ORDER SHEET - PHARMACY

Place **patient identification sticker** and/or **two patient identifiers.**

ACTH (Cosyntropin) Stimulation Test Orders

Ht _____ Wt _____kg

ORDERS GOOD FOR THE YEAR OF 20_____

☐ **ADMIT TO ASU OUTPATIENT**

Diagnosis:

Allergies:

Vital Signs:

☐ Inform Lab of Testing

☐ Start Saline Lock

☐ Immediately administer Cosyntropin 250 mcq IV over 2 minutes

Timed Labwork: ☐ 0 Minutes ☐ 30 Minutes ☐ 60 Minutes

☐ Remove Saline Lock

☐ Discharge when criteria met.

Nurse Signature: ____________________ Date: __________ Time: _________

Qualified Medical Provider Name (Print) : ______________________________

Signature: __________________________ NPI# _________________

Phone Number: _____________ Date: ___________ Time: __________

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