Lewis County Health System

7785 North State Street
Lowville, New York 13367
Phone 315-376-5200
Fax 315-376-5153
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): 4

**SUBJECT:** **INFUSION REQUEST**

**NOTES:** _____

Lewis County Health System
Your Health Partner



## *OUTPATIENT SERVICES REQUEST CHECKLIST*

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

**Patient Name** _____ **DOB** _____ **Patient Phone #** _____

**Height** _____ **Weight** _____ **Gender** _____ **Allergies** _____

**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 _____

☐ **Patient Demographic Cover Sheet**

☐ **LCGH specific Order Sheet completed in full?**

- ☐ Patient's name
- ☐ Patient's DOB
- ☐ Diagnosis
- ☐ Patient's current height and weight
- ☐ Allergies
- ☐ Signed, dated, and timed by ordering physician

☐ **Consent completed** (for blood products including IVIG)

☐ **H&P written within 30 days** (which includes 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** _____

Lewis County Health System

DOCTOR'S ORDER SHEET

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

# PHLEBOTOMY

**ORDERS GOOD FOR THE YEAR OF 20_____**

☐ **Admit to ASU Outpatient**

**Diagnosis:**

**Allergies:**

**Vital Signs:** _____

☐ **Therapeutic Phlebotomy per LCHS policy / protocol (16.9 oz)**

☐ **Other amount to be withdrawn (Please specify):** _____

**Frequency:**

☐ Monthly

☐ Every ___ Weeks

☐ Every ___ Months

☐ Other (Please specify) _____

☐ **Consent signed for Phlebotomy**

☐ **Vital signs per protocol / policy**

**Lab Draws before Phlebotomy:**

☐ Ferritin ☐ CBC ☐ Hgb & Hct ☐ Other (Please specify) _____

**Please identify if there are any special instructions or precautions before phlebotomy draw:**

_____

_____

_____

☐ **Discharge when criteria met.**

**Qualified Medical Provider Name (Print) :** _____

**Signature:** _____ **Phone Number:** _____

**NPI#:** _____ **Date:** _____ **Time:** _____

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315-376-5200

# CONSENT TO PROCEDURE

Patient Identifiers (2)

1. I, _____ hereby authorize Dr. _____ and/or such assistants as may be selected and supervised by him to perform the following procedure: _____
_____

2. Dr. _____ has explained to me alternative procedures and I have been advised of possible risks, consequences and complications which are associated with the procedure described above, included (but not limited to): _____
_____

3. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me about the results of the procedure.

4. I have had sufficient opportunity to discuss my condition and treatment with the doctor, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed Consent to the proposed treatment.

5. It has also been explained, that sometimes during a procedure, it is discovered that an additional procedure is needed immediately. Except as noted below, I authorize the above named doctor to proceed with additional procedures he may deem necessary or advisable during the course of the procedure.

_____
(If none, so state)

6. I consent to the disposal by hospital, authorities of any tissue or body parts which may be removed.

_____ _____
Patient Signature Date and Time

_____ _____
Witness to Signature Date and Time

Because the above patient is an unemancipated minor, ____ years of age, or is unable to sign for the following reasons: _____
_____

the above consent is given on the patient's behalf by:

_____ _____
Closest Relative or Legal Guardian Date and Time

_____
Relationship

_____ _____
Physician's Signature Date and Time



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