We are happy to care for your patient. All PHMG providers are required to enter electronic orders via CareConnect. If you are not a PHMG provider, the following elements are required before we can process the order and schedule your patient for treatment.

* Recent progress note from the ordering provider
* Relevant laboratory results and/or other supporting documentation
* Insurance documentation with the authorization number or reference number
* A valid order (Please use the PeaceHealth approved paper order)

Include the following information on a paper order:

* Patient name AND date of birth
* Date of order issuance
* ICD-10 Dx Code
* Check the boxes of ALL orders you would like to activate
* Provider signature AND printed name at the bottom of each order page
* Name and contact information of the Provider that will be following this patient if different

than the ordering provider

* For blood products, PH Blood and Transfusion Consent form needs to be signed and dated by

the provider and the patient

**Complete the section below and fax back along with the required items above to:**

**PHSJ Infusion Center Intake Coordinator at (360) 501-0146**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINIC ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINIC PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CLINIC FAX # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED PROVIDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT MESSAGE TO PROVIDERS:**

To reduce delays in treatment and phone calls to your office you may participate in the PHSJ formulary process by signing this document. A clinical pharmacist will adjust orders according to PHSJ approved policies and procedures.

***I agree to utilize the PHSJ policies & procedures that have been reviewed by the Pharmacy & Therapeutics committee and authorized by the Medical Executive Committee of PHSJ. This agreement will be issued for the duration of active orders contained within this treatment plan.***

**PROVIDER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**