



TUALITY HEALTHCARE
An OHSU Partner

Tuality Hematology Oncology/Infusion clinic
Phone: 503-681-1064 Fax: 503-681-4120

**Admit to Tuality Community Hospital
AMBULATORY CARE-DAY PROCEDURE**

PATIENT NAME:

BIRTHDATE:

Page 1/1

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK () TO BE ACTIVE.

****INCLUDE****

- Day procedure Infusion /Transfusion order
- Prior authorization form
- Chart notes

1. Diagnosis: _____
2. Admit Reason: _____ Treatment Date request: _____
3. Allergies: _____
4. Height: _____ Weight: _____
5. Diet: _____
6. Activity: _____
7. Labs: see transfusion/infusion order
8. Medication ordered: see Day procedure Infusion/Transfusion order
9. Call physician Dr _____ phone: _____ for any questions or concerns
10. Admitting privileges at Tuality: ____yes ____no. If not, ordering physician must make arrangements with hospitalist for transfer of care.
11. Discharge when transfusion/ infusion complete

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

