SKYLINE HOSPITAL

SCHEDULING REFERRAL
NURSING OUTPATIENT SERVICES (NOPS)

SKYLINE HOSPITAL SURGICAL SERVICES

FAX: 509.493.2838
PHONE: 509.637.2814

REFERRING PROVIDER: _____ **PHONE:** _____

PATIENT NAME: _____ **M / F** **D.O.B.** _____

ALLERGIES: _____

HT (INCHES): _____ **WT (KG):** _____ **PT PHONE #:** _____

DIAGNOSIS:

_____

_____

ICD 10 CODE: _____

TYPE OF SERVICE:

☐ IV Medication ☐ IV Fluids

☐ IM/SQ Medication ☐ Blood Product Transfusion

☐ CVC Lab Draw ☐ Wound Care

☐ CVC/PICC Flush/ Dressing Change/Access ☐ Other _____

ORDER:

DRUG/Product: _____ **Dose:** _____ **Route:** _____

Frequency: _____ **Start Date:** _____ **Stop Date:** _____

PRE-MEDICATION/ADDITIONAL ORDERS/COMMENTS:

_____

_____

LABS: _____ **Frequency (Pre/Post Treatment):** _____

REFERRAL CHECKLIST

☐ PRIOR-AUTHORIZATION COMPLETE **AUTH #** _____
☐ IF NO PRIOR-AUTHORIZATION, PT INSURANCE INFORMATION ATTACHED
☐ FOR IVIG PRODUCTS - FILL OUT ADDITIONAL FORM titled 'IVIG'

PROVIDER SIGNATURE: _____DATE: _____TIME: _____

Skyline Surgical Services will contact the patient to schedule their service date & time.
Any line(s) left blank may result in a delay in patient scheduling and care.

Approved by _____ 10/28/2016