SCHEDULING REFERRAL
NURSING OUTPATIENT SERVICES (NOPS)

SKYLINE HOSPITAL SURGICAL SERVICES

FAX: 509.493.5102
PHONE: 509.637.2814

REFERRING PROVIDER: _____ **PHONE:** _____

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

ALLERGIES: _____

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

RESCUCITATION STATUS: FULL CODE DNR DNI OTHER: _____

DIAGNOSIS:

_____

_____

ICD 10 CODE: _____

TYPE OF SERVICE:

☐ IV Medication ☐ IV Fluids

☐ IM/SQ Medication ☐ Blood Transfusion

☐ CVC Lab Draw ☐ Wound Care

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

ORDER:

DRUG: _____ **Dose:** _____ **Route:** _____

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

PRE-MEDICATION/ADDITIONAL ORDERS:_____

_____

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

REFERRAL CHECKLIST

***please check the appropriate boxes and include required documents along with this form**

☐ PRE-AUTHORIZATION COMPLETE (**AUTH #)** _____

☐ FOR IVIG PRODUCTS - FILL OUT ADDITIONAL FORM - IVIG

PACKET COMPLETE AND FAXED TO SKYLINE SURGICAL SERVICES

PROVIDER SIGNATURE: _____DATE: _____TIME: _____

*Skyline Surgical Services will contact the patient confirming their procedure date & time

Approved by _____ 8/31/2016