

**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:

TYPE OF SERVICE:

- | | |
|--|--|
| <input type="checkbox"/> IV Medication | <input type="checkbox"/> IV Fluids |
| <input type="checkbox"/> IM/SQ Medication | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> CVC Lab Draw | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> CVC/PICC Flush/
Dressing Change/Access | <input type="checkbox"/> Other _____ |

ICD 10 CODE: _____

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