Inpatient Chemotherapy

REQUEST FORM

Please fax completed form and treatment protocol information to ***203.265.3994***
Please allow 5 business days from receipt of all clinical information to process request

Member's Name:	Member's Date of Birth (MM/DD/YYYY):
Member's ID # (9 characters):	Date of Request:
Date of Admission (MM/DD/YYYY):	Anticipated Number of Days:

Facility Name:	Facility CMAP ID:	
Diagnosis:	Diagnosis Code(s):	
Admitting MD Name:	Admitting MD CMAP ID:	
Name of Contact:	Phone:	Fax:

Member's Age:	Member's Weight:	History of renal impairment or heart failure:
Risk for tumor lysis syndrome (if yes, explain): ☐ Yes ☐ No		Is this treatment part of a clinical trial (if yes, a copy of the IRB must be submitted): ☐ Yes ☐ No
Drug(s) / Dosage(s):		
Type of Infusion: ☐ Intermittent ☐ Continuous If continuous, over how many hours? _____ Days _____		IV Fluids: ☐ No ☐ Yes If yes, how many mL/h? _____ Days _____