



ADULT AMBULATORY INFUSION ORDER

3/2023

PAR-Q for iv iron for OB patient

NAME:  
BIRTHDATE:  
INSURANCE:  
PROVIDER NAME:  
CLINIC NAME and Phone number:

Patient identification

Patient NAME & DATE OF BIRTH must be complete at the top of this form. Form will be returned if left blank.

**PAR-Q for iv iron for pregnant patients:**

- ✓ This form verifies that I have reviewed the risks and benefits of iron infusion in pregnancy with patient listed at top of this form. PAR-Q and consent are complete.

Provider's printed name: \_\_\_\_\_

Provider's signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Outpatient Infusion Services Intake Team:**

Please check the appropriate box for the patient's preferred infusion center location:

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> PORTLAND         | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> MEDFORD          | Phone-541-732-7000 Fax-541-732-3939 |
| <input type="checkbox"/> HOOD RIVER       | Phone-541-387-6445 Call for fax #   |
| <input type="checkbox"/> SEASIDE          | Phone-503-717-7650 Fax-503-470-3146 |
| <input type="checkbox"/> NEWBERG          | Phone-503-537-6040 Fax-503-205-8720 |