SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

SIUE HEALTH SERVICE
0222 STUDENT SUCCESS CENTER
EDWARDSVILLE, IL 62026-1055
TELEPHONE: 618-650-2842
FAX: 866-579-9876

THERAPEUTIC INJECTION ORDERS

Therapy will not be provided until this form AND medical records have been received by our office *(please do not say "see attached").* **Please also send medical records, treatment plan, and additional relevant information with form.**

Patient Information:

Name: _____ SIUE ID #_____
DOB: _____ Phone # _____

External Order Details:

Ordering Provider's Name _____
Provider's Facility/Organization _____
Address: _____
Phone # _____ Fax# _____
Office Hours of Operation: _____

Treatment Details:

Patient Diagnosis/ Indication: _____
Type of Injection Therapy: _____
Injection Site: _____
Medication/Substance: _____
Dosage/Strength: _____
Schedule/Frequency of Injections: _____
Directions for early or late schedule, if applicable _____
Date of Last Administration: _____
Instructions for adverse reactions (ie: Epipen, Antihistamine, etc) _____
_____
Post Care Instructions _____
Post administration waiting period, if applicable: _____
Any Additional Specific Instructions: _____
_____
Next Follow up Appointment with Ordering Provider _____
Expiration Date of Orders _____

**Please note that our role in this process is limited to the administration of the injection according to the instructions provided. We will not be responsible for the management of the patient's ongoing care, follow-up, or any related issues that may arise after the procedure.

Provider Signature_____**Date**_____

Reviewed by: _____ Date_____