**CATHOLIC Medical CENTER**

**STANDING ORDER REQUEST FORM**

100 McGregor Street
Manchester, NH

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## PATIENT INFORMATION

Patient Name  _____   _____

                 Last                First           Initial        Date of Birth

Address       _____   _____

                 Street                                 Telephone

                 _____   _____   _____

                 City                                State     Zip Code

Medical Record # _____           EMR #_____

                    Lab use

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

## STANDING ORDER INFORMATION

Tests        _____       _____       _____

ICD codes     _____       _____       _____

Frequency     ☐ **Daily**        ☐ **Weekly**       ☐ **Monthly**

                 ☐ **Quarterly**     ☐ **Other**       _____

                                                         **PRN is not valid**

Effective date   _____     _____    Duration of the standing order

                  Start Date          End Date       is limited to one year.

Comments     _____

Requested by    _____

                  Providers Name                   Practice Name

➡ **Fax the completed form directly to Catholic Medical Center Client Support @ 625-4511 for timely initiation of the standing order. This form may also be given to the patient to initiate the order.**

7-2-2007ad  edited 9-21-2009