

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

ICD-10 Diagnosis: _____

Rx:

Cyanocobalamin 1000 mcg/mL injection

Route:

Intramuscular Deep subcutaneous

Frequency: Once Every 4 weeks Every 2 weeks Weekly Other: _____

Duration: Once 6 months 1 year Other: _____

Other orders/comments: _____

Prescriber printed name: _____

Prescriber full address: _____

Office phone number: _____

Office fax number: _____

Prescriber signature

Date

Time

Questions? Call (419) 591-3858. Please fax completed form to (419) 592-4004.



**VITAMIN B12 (CYANOCOBALAMIN)
INJECTION ORDER FORM**

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TRIAL

This document is currently being trialed.