PREMIER INFUSION CARE

PRESCRIPTION REFERRAL FORM

Referral Line (866) 365-2525 | Referral Fax (866) 383-2525

*Complete and attach signed order, current labs, history and physical, then fax to Premier Infusion Care.

REFERRAL FACILITY NAME _____

REFERRAL CONTACT NAME _____ ☐ HOSPITAL ☐ MD ☐ RN AGENCY ☐ INSURANCE ☐ CASE MGR

CONTACT PHONE _____ **CONTACT FAX** _____

Patient Information:

LAST NAME _____ FIRST NAME _____

SS# _____/_____/_____ DOB _____/_____/_____

HOME PHONE _____ WORK PHONE_____ CELL PHONE _____

PARENT DETAILS / GUARDIAN _____

START OF CARE DATE _____/_____/_____ HT:_____WT:_____ ☐ LBS ☐ KG

Primary Insurance (FAX COPY OF CARD)

POLICY # _____ GROUP # _____

INSURANCE PHONE # _____

Secondary Insurance (FAX COPY OF CARD)

POLICY # _____ GROUP # _____

INSURANCE PHONE # _____

PRESCRIPTION CARD _____ POLICY # _____

CARRIER: _____ PHONE # _____

Intravenous

- ☐ TPN
- ☐ IVIG
- ☐ DHPG
- ☐ HYDRATION
- ☐ VISTIDE
- ☐ ANTIBIOTIC
- ☐ OTHER

Notes

_____

_____

_____

Access / Line

_____

_____

_____

1st Dose at Home

☐ YES ☐ NO

Injectables

- ☐ PEGASYS
- ☐ COPEGUS
- ☐ PEG-INTRON
- ☐ REBETROL
- ☐ SEROSTIM
- ☐ REBIF
- ☐ EPOGEN
- ☐ REMICADE
- ☐ NEUPOGEN
- ☐ GROWTH HORMONE
- ☐ NEULASTA

OTHER

_____

_____

_____

_____

Home Health (SELECT ONE)

- ☐ PIC to arrange nursing
- ☐ Patient already arranged with the following Home Health

Home Health Name _____

Home Health Ph# _____

Other_____

Prescription / Order Instructions

Respiratory

NAME _____

DOSE _____

OF REFILLS _____

Enteral Nutrition

ROUTE _____

PRODUCT _____

ORDERS _____

Physicians Signature:

_____

PRINT Prescribing Physicians Name:

_____