



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

Physicians Signature:

PRINT Prescribing Physicians Name:
