PREMIER INFUSION CARE

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

COMMUNITY HEALTH ACCREDITATION PROGRAM CHAP

PRESCRIPTION REFERRAL FORM

Complete and attach signed orders, current labs, history and physical, then fax to Premier Infusion Care.
Premier Infusion Care will confirm acceptance of service.

REFERRAL FACILITY NAME _____

REFERRAL CONTACT NAME _____ ☐ Hospital ☐ MD ☐ RN Agency ☐ Insurance ☐ Case Manager

CONTACT PHONE _____ CONTACT FAX _____

PATIENT INFORMATION

PATIENT LAST _____ PATIENT FIRST _____

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

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PARENT DETAILS/GUARDIAN _____

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

ALLERGIES:_____

PRIMARY INSURANCE (FAX COPY OF CARD)		SECONDARY INSURANCE (FAX COPY OF CARD)	
POLICY #	GROUP #	POLICY #	GROUP #
INSURANCE PHONE #		INSURANCE PHONE #	
PRESCRIBTION CARD		POLICY #	
CARRIER:		PHONE #	

PRESCRIPTION/ORDER

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 _____

Prescribing Physicians Signature

_____

Print Prescribing Physicians Name

_____