

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)

POLICY # _____ GROUP # _____

INSURANCE PHONE # _____

SECONDARY INSURANCE (FAX COPY OF CARD)

POLICY # _____ GROUP # _____

INSURANCE PHONE # _____

PRESCRIPTION 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

CONFIDENTIALITY NOTICE

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