INFUSION ORDER

Precisionhc
advanced specialty healthcare

Locations: Nashville, Cool Springs, Columbia, Murfreesboro, Knoxville, Memphis, Tulsa, and Arkansas
Call: 615-367-1444
Toll Free: 888-665-1444
Fax: 888-615-1445

DEMOGRAPHIC INFORMATION

Last Name: _____
First Name: _____
SSN: _____
Date of Birth: _____
Parent/Guardian: _____
Home Phone: _____
Work Phone: _____
Home Address: _____
Apt. Number: _____
City: _____
State: _____
Zip: _____
Height: _____
Current Weight: _____

INSURANCE INFORMATION (*OR*, FAX COPY OF INSURANCE & PRESCRIPTION CARDS)

Primary Insurer: _____
Subscriber Name: _____
Policy Number: _____
Group Number: _____
Insurer Phone: _____
Secondary Insurer: _____
Subscriber Name: _____
Policy Number: _____
Group Number: _____
Insurer Phone: _____

DIAGNOSIS / DIAGNOSES ***ATTACH ALL SIGNIFICANT CLINICAL INFORMATION***

❑ **Primary Dx:** _____ **ICD-10 Code:** _____
❑ **Secondary Dx:** _____ **ICD-10 Code:** _____

LIST ANY ALLERGIES:

_____

CURRENT AND FAILED TREATMENTS: (C=Current, F=Failed)

C/F Drug Name and Dosage

_____ _____
_____ _____
_____ _____
_____

TB SKIN TEST: SUGGESTED ANNUALLY FOR MOST BIOLOGICS

Administered Date: _____

❑ Needs TB Skin Test
❑ Please Arrange

Results
❑ Negative
❑ Positive

ORDERS

PLACE OF DELIVERY: ❑ Precision Infusion ❑ MD Office ❑ Patient Home

	DRUG NAME (Include Any Premedications)	DOSE / STRENGTH	DIRECTIONS
❑			
❑			
❑			

Start of Care Date: **Refill x:**

LABS AND FREQUENCY / ADDITIONAL ORDERS

PHYSICIAN INFORMATION

Physician Name: _____
Office Contact: _____
Physician Address: _____
Physician Signature: _____
Phone: _____
Fax: _____
Physician NPI: _____
Date: _____