INJECTION ORDER

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

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

Primary Insurer: ______________________ Secondary Insurer: ______________________
Subscriber Name: ______________________ Subscriber Name: ______________________
Policy Number: ______________________ Policy Number: ______________________
Group Number: ______________________ Group Number: ______________________
Insurer Phone: ______________________ 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: ___________ Results
❑ Needs TB Skin Test ❑ Negative
❑ Please Arrange ❑ 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: ______________________ Phone: ______________________
Office Contact: ______________________ Fax: ______________________
Physician Address: ______________________ Physician NPI: ______________________
Physician Signature: ______________________ Date: ______________________