INFUSION ORDER FORM

Locations: Cool Springs, Knoxville, Memphis, Murfreesboro, Nashville, and NW 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:** _____

PHYSICIAN INFORMATION

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

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:** One year _____ **Specify** _____

* By signing this form and utilizing our services, you are authorizing Precision and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

LIST ANY ALLERGIES:

LABS AND FREQUENCY/ ADDITIONAL ORDERS