INJECTION ORDER FORM

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

PHYSICIAN INFORMATION

Physician Name: _____
Office Contact: _____
Physician Address: _____
Physician Signature: _____

Phone: _____
Fax: _____
Physician NPI: _____
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