

WWW.PRECISIONHC.COM Phone: 615.367.1444 FAX: 888.615.1445

	lication/ Order Change Benefits Verification Refill / Ren w Order Required) Only	newal	
Precision Healthcare can accept only original prescription drug or	ders from patients, and faxed prescriptions from the prescribing practitioners.		
PATIENT INFORMATION	PHYSICIAN INFORMATION		
Name:	Referring Physician:		
DOB: SS#	Practice Address:		
Phone #	Office Contact:		
Email:			
	NPI / TIN:		
	MEDICATION ORDER		
Medication Requested			
Dose/Route/Frequency			
*ICD-10 Code/Description *ICD-10 Code/Description Premedications: (If desired, please list below	Refills x 1 year (unless otherwise specifi May use Precision Allergy Reaction Prot	Refills x 1 year (unless otherwise specified) May use Precision Allergy Reaction Protocol LAB ORDERS FOR PRECISION NURSING TO DRAW	
•	(please specify)		
	Orders:		
	Frequency:		
	NOTES (ADDITIONAL INFO OR ORDERS)		
Referring Physician's Signature	Date		
R	EQUIRED DOCUMENTATION		
☐ Recent Officenotes (along with any therapies	tried and outcomes)	cal	
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet ☐ Report Allergies			
ATTACH REOL	JIRED LAB RESULTS (For New Referrals Only)		
☐ Attach pertinent labs for requested therapy	THE LAB RESOLITS (FOR NEW NEIGHBIS SHIP)		
APPOINTMENT DATE AND TIME	•		