

VITAL CARE OF ROANOKE REFERRAL FORM

*#Please Attach Copy of Insurance Cards (Front & Back)***

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: <input type="radio"/> M <input type="radio"/> F
City:	State:	Zip:	
Phone:	SSN#	Prescriber Name:	
Insurance Information			Prescriber NPI:
Insurance Plan:	Insurance Plan:	Nurse/Key Contact:	
Policy #	Policy #	Phone:	
Plan I.D. #	Plan I.D. #	Fax:	Email:

Diagnosis & Clinical Information

#Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis

Diagnosis Code: _____

Other: _____

TB/PPD Test: Positive Negative Date: _____

Allergies: _____

NKDA

Height: _____ Weight: _____

Site of Care: Home AIC Other: _____

Prescription and Others

Medication	Dose	Frequency	Duration
Medication	Dose	Frequency	Duration
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Pre-medication & other medications · Infusion supplies as per protocol · Anaphylaxis kit as per protocol	<input type="checkbox"/> Acetaminophen	mg PO prior to infusion mg <input type="checkbox"/> PO <input type="checkbox"/> IV	Flush Protocol · NaCl 0.9% 10ml · Before & after infusion
	<input type="checkbox"/> Diphenhydramine		
	<input type="checkbox"/> 250ml 0.9%NaCl for hydration		
	<input type="checkbox"/> Other		

Medical Information

Physician Signature: _____ Date: _____

I authorize Vital Core infusion Services LLC and its representatives to initiate on insurance prior authorization process that is required for this prescription and for any future refills of the some prescription for the patient listed above which I order i understand that i can revoke this designation at only time by providing written notice to Vital Core.

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached documents) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.