EMORY HEALTHCARE

PS-1070

DTC Specialty Infusion Order
FAX orders to: 404.501.5703
Phone: 404.501.5580

Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ❑ M ❑ F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Order Information

Diagnosis: _____ ICD-CM Code: _____

Infusions:

☐ IVIG:_____ ☐ IV Solu-Medrol

☐ IV Remicade Last TB test:_____ Result:_____

☐ IV Iron: ☐ Venofer ☐ IV Dextran ☐ Ferrlecit ☐ other:_____

Dose:_____ Pt weight:_____

Pre-med: ☐ Benadryl 25mg ☐ PO or ☐ IV
☐ Tylenol 650 mg PO
☐ Other:_____

Labs: _____

Dates of treatment: _____

Other: _____

Injections:

☐ Xolair (Omalizumab) _____ mg every _____ weeks for _____ months

☐ Other_____

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____

Physician Address: _____ Phone #: _____ Fax #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ **Date:** _____ **Time:** _____