



FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
 DALLAS / 3410 Worth St., Ste. 790, Dallas TX 75246

TEL: **817-336-1640** FAX: **817-336-1643**

PATIENT INFORMATION:				PRESCRIBER INFORMATION:					
Patient Name:				Prescriber Name:					
Address 1:				DEA:					
Address 2:				NPI:		License:			
City:		State:	Zip:	Address:					
Home Phone:			Alt:	City:		State:	Zip:		
DOB:		SSN:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Phone:			
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				POC:		Email			
INSURANCE INFORMATION: Complete entirely or fax front and back of patient's Insurance Cards									
Primary Insurance:		Subscriber:		ID#		Name of Insurer:	Phone:		
Secondary Insurance:		Subscriber:		ID#		Name of Insurer:	Phone:		
Prescription Card:		Name of Insurer:		ID#		BIN:	PCN: GROUP:		
CLINICAL INFORMATION: (Attach additional sheets if necessary)									
TYPE IV ACCESS	<input type="checkbox"/> Peripheral IV	<input type="checkbox"/> Port: Needle size _____	Accessed _____	<input type="checkbox"/> Midline: _____	lumens				
	<input type="checkbox"/> PICC: _____	lumen	<input type="checkbox"/> PICC placement needed						
ICD DIAGNOSIS CODE:				PATIENT HISTORY:					
<input type="checkbox"/>				Weight _____		<input type="checkbox"/> kg <input type="checkbox"/> lb.	Height _____	<input type="checkbox"/> cm <input type="checkbox"/> in	
<input type="checkbox"/> Other:				<input type="checkbox"/> NKDA <input type="checkbox"/> Allergies					
PROVIDER ORDERS:									
MEDICATION	DRUG			DOSE	ROUTE	FREQ	THERAPY LENGTH	START DATE	STOP DATE
FLUSH PROTOCOL	Use SASH method for flushing protocol: S-Saline, A-Administer Medication, S-Saline, H-Heparin (100 units/ml flush)								
SUPPLIES	<input type="checkbox"/> Supplies and pumps necessary to maintain and administer medication								
ANAPHYLAXIS KIT	<input type="checkbox"/> Anaphylaxis Kit: Diphenhydramine 50 mg (1 vial); Epinephrine 1:1000 (2 vials); Supplies for administration • Allergic response – As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes • Anaphylaxis – As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes or deep IM injection; Epinephrine 1:1000 solution: (0.4 mg) subcutaneous injection; If needed, may repeat in 20 minutes times 1 dose								
LABS	Baseline labs on admission and then drawn weekly each MONDAY while on therapy: <input type="checkbox"/> CBC with differential <input type="checkbox"/> CMP <input type="checkbox"/> CRP Quant <input type="checkbox"/> ESR <input type="checkbox"/> Vancomycin trough - Mon and Thurs <input type="checkbox"/> Daptomycin - CK Weekly <input type="checkbox"/> Other _____								

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber Signature: _____ Date: _____