PRESCRIPTION(Rx)/REFERRAL

FAX: 725.228.5220

☐ New Prescription/Referral
☐ Prescription Refill

eMediate INFUSION

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

MEDICATION/STRENGTH:

ROUTE: ☐ Peripheral IV ☐ Port ☐ PICC ☐ SubQ ☐ Midline ☐ IM

DIRECTIONS:

DIAGNOSIS:

ICD-10 CODE:

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:
☐ OK to use

PRESCRIBER SIGNATURE: x | Date (Valid for 1 year):

I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.

Please attach the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results