○ New Prescription/Referral
○ Prescription Refill

PRESCRIPTION(Rx)/REFERRAL

Rx:

Patient Name:

Patient Weight: kg

DOB:

MEDICATION/Strength:

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

Directions:

DIAGNOSIS:

ICD-10 CODE:

Pre-Medication:

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef _____mg IVP
- ☐ Tylenol _____mg PO ☐ 650mg ☐ 975mg
- ☐ Benadryl _____mg ☐ 25mg ☐ 50mg ☐ IV ☐ PO

ANA Kit Protocol:

- ☐ OK to use

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone: **Other:** **Email:**

Office Mailing Address:

Check that the following are included:

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