PORT CARE/LABS

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx:

Patient Name:

Patient Weight: kg

DOB:

PORT CARE:

- ☐ Perform weekly maintenance of implanted port **OR**
- ☐ Perform monthly maintenance of implanted port
- ☐ Access the port via huber needle
- ☐ Flush with 10ml NS
- ☐ Pack with the mixture of 2.5 ml NS and 2.5 ML heparin
- ☐ Deaccess port

LABS:

- ☐ CBC, CHEM, CRP, ESR
- ☐ CPK

Reminder:

Please send all supplies needed.

Medication:

ICD 10 **DX:**

Where to send results:

Phone #: _____

Fax #: _____

Physician Signature

NPI #:

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:

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

Office Mailing Address:

Please include the following

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

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.