

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
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
Lab Results

Insurance attached
Clinical progress notes

Diagnosis(supporting)
Medication list

History & Physical
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.