Physician
Infusion Orders

T: 832.939.8137 Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478 F: 832.939.8128

Patient Name: ________________ Social Sec #: __________ Weight: ____ lbs

D.O.B: __________ Sex: Male ____ Female _____ Height: ____ lbs

Phone: ______________

Address: ________________________ City: __________ State: ____ Zip Code: __________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis: ________________________ ICD-10 Code: ______________

Allergies: ____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

PHYSICIAN ORDERS

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Once we recieve all necessary documentation, we will schedule the patient's treatment.

PHYSICIAN INFORMATION

By signing this form and utilizing ur services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ________________________ Date: ______________

Physician Name: ________________________

Phone: ______________ Fax: ______________ Contact Person: ______________