Vital Care of Greenville
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vitalcare® INFUSION SERVICES of GREENVILLE

LOCAL

NEUROLOGY REFERRAL

----Patient Info----

Name:	Street Address:	
DOB:	City/State/ZIP:	
Primary Phone #:	Email:	
Alternate Phone #:	Height(inches):	Weight: [Specify Lbs/Kgs]
Insurance (primary and secondary)		
Insured Name:	Please send:	
Insured DOB:	-Insurance Card(s) -Pertinent Labs -Prior Treatments -Medical Records	

----Prescription----

☐ **IV Immunoglobulin**

☐ Load Dose
- ☐ 0.4 gm/kg ☐ 1 gm/kg ☐ 2 gm/kg ☐ _____ gm
- Frequency: _____

☐ Maint Dose
- ☐ 0.4 gm/kg ☐ 1 gm/kg ☐ 2 gm/kg ☐ _____ gm
- Frequency: _____

☐ **Other Specialty Medication**

Drug: _____

☐ Insurance preferred biosimilars not allowed

Dose/Frequency/Instructions:

Site of care: ☐ Private Suite ☐ Home

Pre-Meds: ☐ Acetominophen ☐ Diphenhydramine ☐ Hydration ☐ Other

Specify Dose: _____ _____ _____ _____

----Clinical----

Diagnosis: ICD-10 Code: Notes:

Allergies: IV Access: ☐ PIV ☐ Port

Lab Orders: **Frequency**

- ☐ CBC/Diff _____
- ☐ CMP _____
- ☐ IgG w/Subclass 1-4 _____
- ☐ Quant. IG _____
- ☐ Other _____
- _____
- _____

Prescriber Information

Name: _____ NPI: _____

Practice: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Fax: _____

Nurse/Contact Name: _____

I authorize Vital Care Infusion Services LLC and it's 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 or electronic notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED