Vital Care of Greenville
274 Commonwealth Dr, Ste C
Greenville SC, 29615

LOCAL PULMONOLOGY

vitalcare® INFUSION SERVICES

GREENVILLE & SPARTANBURG

P: 864.438.2800 FAX: 864.438.2801

Vital Care of Spartanburg
896 W St John St
Spartanburg, SC 29301

LOCAL PULMONOLOGY

----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----

*Anaphalaxis & flush orders per pharmacy protocol

☐ **Glassia**
Dosing/Directions: _____

☐ **Aralast**
Dosing/Directions: _____

☐ **Prolastin**
Dosing/Directions: _____

☐ **Other:** _____
Dosing/Directions: _____

Pre-Meds: ☐ Acetominophen ☐ Diphenhydramine ☐ Hydration ☐ Other
Specify Dose: _____

----Clinical----

*Port access per pharmacy protocol

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