



**GREENVILLE
& SPARTANBURG**



PULMONOLOGY

P: 864.438.2800 FAX: 864.438.2801

PULMONOLOGY

----Patient Info----

Name:		Street Address:	
DOB:		City/State/ZIP:	
Primary Phone #:		Email:	
Alternate Phone #:		Height(inches):	Weight: <small>[Specify Lbs/Kgs]</small>
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:	Prescriber Information	
<u>Frequency</u>		
CBC/Diff	Name: _____	NPI: _____
CMP	Practice: _____	
IgG w/Subclass 1-4	Address: _____	
Quant. IG	City/State/ZIP: _____	
Other	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

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