

VITAL CARE OF SIOUX FALLS REFERRAL

*#Please Attach Copy of insurance Cards (Front & Back)**

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: ☐ M ☐ F
City:	State:	Zip:	
Phone:	SSN#	Prescriber Name:	
Insurance Information			Prescriber NPI:
Insurance Plan:	Insurance Plan:	Nurse/Key Contact:	
Policy #	Policy #	Phone:	
Plan I.D. #	Plan I.D. #	Fax:	Email:

Diagnosis & Clinical Information

#Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis

☐ Diagnosis Code:	TB/PPD Test: ☐ Positive ☐ Negative ☐ Date: _____
☐ Other: _____	Allergies: _____

☐ NKDA	
Height: _____	Weight: _____
Site of Care: ☐ Home ☐ AIC ☐ Other: _____	

Prescription and Others

Medication	Dose	Frequency	Duration
Medication	Dose	Frequency	Duration
Medication	Dose	Frequency	Duration

Pre-medication & other medications	☐ Acetaminophen	mg PO prior to infusion	Flush Protocol
· Infusion supplies as per protocol	☐ Diphenhydramine	mg ☐ PO ☐ IV	· NaCl 0.9% 10ml
· Anaphylaxis kit as per protocol	☐ 250ml 0.9%NaCl for hydration		· Before & after infusion
	☐ Other		

Medical Information

Physician Signature: _____ Date: _____

I authorize Vital Care infusion Services LLC and its representatives to initiate on 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 notice to Vital Care.

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached documents contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.