vitalcare®
INFUSION SERVICES
of SIOUX FALLS

1020 S Cliff Ave., Sioux Falls, SD 57104
P / 605-220-7824 · F / 605-220-7980
www.vitalcaresiouxfalls.com
info@vitalcarenorthtexas.com

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:

☐ Other: _____

TB/PPD Test: ☐ Positive ☐ Negative ☐ Date: _____

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

- Infusion supplies as per protocol
- Anaphylaxis kit as per protocol

☐ Acetaminophen
☐ Diphenhydramine
☐ 250ml 0.9%NaCl for hydration
☐ Other

mg PO prior to infusion

mg ☐ PO ☐ IV

Flush Protocol

- NaCl 0.9% 10ml
- Before & after infusion

Medical Information

Physician Signature: _____ Date: _____

I authorize Vital Core infusion Services LlC and its representatives to iniciate on insurance prior authorization process that is required for this prescription and for any future refills of the some prescription for the patient listed above which I order i understand that i can revoke this designation at only time by providing written notice to Vital Core.

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