



PATIENT INFORMATION

Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is this a new Infuse IQ Healthcare Patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Order date:	Weight: kg lbs	Height: m in
Drug allergies:	<input type="checkbox"/> NKDA	<input type="checkbox"/> YES. Please specify.

ICD-10 diagnoses:		

SUPPORTING DIAGNOSTIC AND LABORATORY DATA

<input type="checkbox"/> CBC	<input type="checkbox"/> BMP	<input type="checkbox"/> Serologies
Other:		

MEDICATION

Name	Dose	Frequency	Refills

ORDERING PHYSICIAN INFORMATION

Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Thank you for choosing Infuse IQ