INFUSION THERAPY

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Circle one: M F	D.O.B.
Home Address:	City:	State:	Zip:
Height:	Weight:	Allergies:	
Preferred Method of Contact: ☐ Email ☐ Phone (Home):	Phone (Cell):	Phone (Work):	
Email: _____ Last 4 of SSN #: _____	Primary Language _____		

Insurance

Primary Insurance: **Complete and Attach Copies of card*	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity Date:

Primary Diagnosis:_____

Secondary Diagnosis:_____

Access: ☐ None or ☐ Type

Prescription

	Anti-Infective Therapy 1		Anti-Infective Therapy 2	
Therapy Ordered	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other:	Dose:_____ Frequency:_____ Start Date:_____ Duration:_____	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other:	Dose:_____ Frequency:_____ Start Date:_____ Duration:_____
Labs	☐ BMP, CBC w/ differential q Monday. ☐ Trough level after 3rd dose and with routine Monday labs if Vancomycin or Aminoglycoside. ☐ Other:_____			
Flushing	☐ NS 5 ml SASH and prn ☐ Heparin 20 units ☐ Heparin 100 units SASH and prn		Patient has signed a DNR: ☐ Yes ☐ No	

Anticipated time of Discharge Home: Time:_____ **Date:**_____

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____ *All the supplies including syringes and needles will be dispensed if requested above.*

☐ Patient is interested in support programs

Physician Signature: _____ Per state law must write out DAW (if applicable): _____ Date: _____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.