



Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: M F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Order Information

Diagnosis: _____ **ICD-CM Code:** _____

Infusions:

IVIG: _____ IV Solu-Medrol

IV Remicade Last TB test: _____ Result: _____

IV Iron: Venofer IV Dextran Ferrlecit other: _____

Dose: _____ Pt weight: _____

Pre-med: Benadryl 25mg PO or IV
 Tylenol 650 mg PO
 Other: _____

Labs: _____

Dates of treatment: _____

Other: _____

Injections:

Xolair (Omalizumab) _____ mg every _____ weeks for _____ months

Other _____

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____
Physician Address: _____ Phone #: _____ Fax #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ **Date:** _____ **Time:** _____