

TPN Referral Form

To		From	
Name of Practice/Facility		Phone	Fax
Intake Phone		Number of Pages including Cover	
Date		Home Phone	
Patient Name		Date of Birth	
Patient Home Address		City	State Zip
Diagnosis		Gender <input type="radio"/> M <input type="radio"/> F	
Are TPN Orders attached to this Referral Form? <input type="radio"/> Y <input type="radio"/> N		First Dose? <input type="radio"/> Y <input type="radio"/> N	
Patient Eating? <input type="radio"/> Y <input type="radio"/> N		Estimated Length of Therapy	
IV Access <input type="radio"/> PICC <input type="radio"/> Port <input type="radio"/> Central <input type="radio"/> Other:		<input type="radio"/> Y <input type="radio"/> N	
Hospital Discharge Summary attached? <input type="radio"/> Y <input type="radio"/> N		Most Recent Labs (date) <input type="checkbox"/> Attached	
Start of Care Date		Spanish-speaking Only <input type="checkbox"/>	
History & Physical <input type="checkbox"/> Attached	Marital Status <input type="radio"/> S <input type="radio"/> M <input type="radio"/> D <input type="radio"/> W		Diabetic? <input type="radio"/> Y <input type="radio"/> N
HT	WT	Allergies	
Other home health care needs?			
Physician signing discharge orders		Fax	Phone
Physician who will follow patient at home (if different than above)			
Physician Name		Fax	Phone
Patient Demographics <input type="checkbox"/> Attached		Delivery Address (if different than home)	
Patient Cell Number		Patient Work Number	
Emergency Contact Outside Home		Relationship	Phone
Caregiver Name		Caregiver Teachable? <input type="radio"/> Y <input type="radio"/> N	Phone
Patient Independent? <input type="radio"/> Y <input type="radio"/> N		Patient Teachable? <input type="radio"/> Y <input type="radio"/> N	Homebound? <input type="radio"/> Y <input type="radio"/> N
Insurance		ID#	Phone
Medi-Cal ID#		Issue Date	

I authorize Vital Care Infusion Services LLC and its representatives to initiate any 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.

Physician Signature: _____
Date: _____

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

The attached document(s) 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.