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Please call (800) 940-5151 before faxing to ensure delivery.

Fax: (800) 676-3127

PLEASE ATTACH DEMOGRAPHICS AND SUBSCRIBER'S INSURANCE CARD/INFORMATION.

Patient Name: _____

Diagnosis: _____

Surgical Procedure: _____

Ordering Physician: _____

Phone: () _____

Type of Medication/Dose/Frequency:

Rx: _____

Duration Rx: _____

Next Dose Due: _____

Please attach a specific Rx for TPN Formula.

Allergies: _____

Height: _____ Weight: _____

HHC to insert PIV or Midline

Type of Line: PICC Groshong PIV Port Other: _____

Number of Lumens: _____

Has the patient had this IV medication before? Yes No

If no, please order ANA kit.

Labs Ordered: _____

Physician's Signature: _____ Date: _____

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