Kaweah Health Medical Center

HOME INFUSION PHARMACY / INTAKE FORM

PHONE NUMBER: (559) 624-4244

PATIENT INFORMATION

REFERRAL DATE:	START OF CARE DATE:	
PATIENT NAME:	☐ MALE ☐ FEMALE	SSN:
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:
CAREGIVER/LEGAL GUARDIAN:	RELATIONSHIP:	PHONE:
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE:
DOB:	HEIGHT:	WEIGHT:

PATIENT CLINICAL INFORMATION

ALLERGIES:

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS:

THERAPIES: ☐ TPN ☐ ENTERAL ☐ ANTIBIOTIC ☐ HYDRATION ☐ PAIN MANAGEMENT ☐ OTHER:

MEDICATION: FREQUENCY: START DATE:
DOSE: STOP DATE:

MEDICATION: FREQUENCY: START DATE:
DOSE: STOP DATE:

TYPE OF ACCESS: ☐ PICC ☐ MIDLINE ☐ HICKMAN ☐ PORT ☐ PERIPHERAL
NUMBER OF LUMENS: DATE INSERTED:
CATHETER CARE ORDERS: ☐ SALINE FLUSH ☐ SALINE FLUSH AND HEPARIN LOCK ☐ DEACCESS AFTER THERAPY COMPLETE

OTHER MEDICATION: ☐ SEE ATTACHED LIST | LAB WORK: ☐ SEE ATTACHED

ORDERING PHYSICIAN NAME: PHONE: LICENSE:
ADDRESS: FAX: NPI:

REIMBURSEMENT INFORMATION

REIMBURSEMENT INFORMATION:

MEDICARE INFORMATION:

MEDICARE HIC #:

PRIMARY INSURANCE: PHONE #: POLICY #: GROUP #:

SECONDARY INSURANCE: PHONE #: POLICY #: GROUP #:

MEDICAID #: ID #: MEDICAL GROUP:

COMPLETED BY: DATE:

☐ ACCEPTED ☐ NOT ACCEPTED INTAKE PERSONNEL

SIGNATURE: _____ DATE: _____

IF NOT ACCEPTED REASON WHY:

FAX #: (559) 625-4915