REFERRAL FORM / CERTIFICATE OF MEDICAL NECESSITY

Infusion Services at Lake City Mediplex
404 NW Hall of Fame Drive
Lake City, FL 32055
Phone – 386 754-3627 Ext – 115
Fax – 386 754 3657
infusion@PrimaryCareMedic.com

A new form must be completed each time medications are changed

Referring Office / Physician Info
Name –_____ NPI _____
Patient Info
Name –_____ D.O.B. – _____
Allergies - _____
Insurance Plan
NAME _____ NUMBER_____
NAME _____ NUMBER_____
NAME _____ NUMBER_____

IV Access
What – PORT-a-cath / PICC line / Hickman / Infusaport / peripheral IV / _____

Nursing orders
_____ Insert and maintain vascular access device (if not present)
_____ Arrange for PICC line insertion
_____ Line site care, specify frequency _____
_____ Blood draw, specify what needs to be done _____
_____ Blood draw, specify frequency _____
_____ In-office Infusion ONLY
_____ Home Infusion preferred – Elastomeric / MiniBag + / CADD Pump
_____ Evaluate patient/caregiver for home infusion therapy
_____ Train, educate patient/caregiver in home infusion therapy
_____ Wound Care

Treatment Plan
Diagnosis requiring IV Therapy
_____
_____

Medication
Name _____ Dosage _____ Freq _____ Duration _____
Name _____ Dosage _____ Freq _____ Duration _____
Name _____ Dosage _____ Freq _____ Duration _____

Additional Orders : _____
_____
I hereby certify / recertify that the above services are required by the patient for medical reasons.

I hereby discontinue the services on this patient.

Date _____ Signature of Physician _____