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) 625-4918