

**Practice
Logo**

**PATIENT INTAKE FORM
NOTIFICATION**

Today's Date: _____ Method of Receipt: _____ Time of call: _____

PATIENT'S NAME:	PATIENT ID NUMBER:	PATIENT SS#:
PATIENT'S HOME ADDRESS:	PATIENT HOME NUMBER:	PATIENT D.O.B.:
-----	PATIENT WORK NUMBER:	PATIENT WEIGHT:
OTHER CONTACT PERSON:	PATIENT CELL NUMBER	Insured BY:
ORDERING PHYSICIAN :	CONTACT PERSON:	DIAGNOSIS:
PHYSICIAN OFFICE ADDRESS:	OFFICE NUMBER:	ORDERED THERAPY:
-----	OFFICE FAX :	START THERAPY WHEN?:
IV ACCESS?: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, type? _____	ICD9:	LOT:

- ◆ Ask for the following information be faxed to our office:
 - Orders on Prescription Pad with Diagnosis & ICD-9 Code Yes No
 - The most current history and physical, medication list, & allergies Yes No
 - **Remicade** - Does the patient have a history of Tuberculosis or exposure Yes No N/A
 - **IVIG** – Need current Crt and Quantitative Serum IGA Yes No N/A
 - **Tysabri** – On immumosuppressants? Yes No N/A
 - The last dictated office visit Yes No
 - Any pertinent lab work (CBC etc.) Yes No N/A
 - Anything additional that our office may need? Yes No
- ◆ Has the Nursing Director or Nurse-in-charge been notified of pending infusion? Yes No

• **Nursing Department**

- ◆ Have you received orders for infusion from ordering physician? Yes No
- ◆ Has the Pharmacist been notified of pending infusion? Yes No N/A
- ◆ Is there anything in the patient's history to prevent CID from doing the infusion? Yes No
- ◆ Is this an IVIG infusion? If Yes, we need a current **Crt** and **Quantitative Serum IGA** Yes No N/A
- ◆ Is this a Remicade infusion? If yes, we need to schedule patient for PPD or CXR. Yes No N/A

• **Nursing Director**

- ◆ Schedule the patient for infusion **Date:** _____ **Time:** _____
- ◆ Has the referring physician/office been notified of appt? Yes No

Message given to: _____

• **Notes**
