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| HCM Logo REV5 COLOR | | 625 S Pear Orchard Ridgeland, MS 39157  Phone: 769-233-8484 Fax: 769-233-8051 | | Enrollment Form | | |
| **Patient Information** | | | **Prescriber Information** | | | |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Prescriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Gender: 🞎 Male 🞎 Female Last 4 of SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Insurance Information** (Please fax a copy of patient’s card including front and back) | | | | | | |
| **Medical Information** (Please attach clinical notes) | | | | | | |
| Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Patient’s Weight: \_\_\_\_\_\_\_\_ lb Height:\_\_\_\_\_\_\_ in | | | |
| **Prescription Information** | | |  | | | |
| **Medication** | **Dose/ Strength** | | **Directions** | | **Quantity** | **Refills** |
| 🞎 \_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |
| 🞎 NS 1000ml | \_\_\_\_\_\_\_\_\_\_\_\_ | | Infuse IV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |
| 🞎 NS | 0.9% 10ml syringe | | Flush line daily IV with 10ml to keep open | | Qs 1 month |  |
| 🞎 Heparin | 10 units/ml 5ml syringe | | Flush line daily IV with 5ml after each NS flush to keep open | | Qs 1 month |  |
| 🞎 PICC line dressing supplies |  | | Change dressing on line weekly and prn to maintain dry and intact dressing. | | QS 1 month |  |
| Nursing Orders: RN to insert peripheral IV; Flush line with NS 0.9% 10 ml per SAS or SASH as indicated | | | | | | |
| Lab Orders:  \* Please fax lab results to physician and Health Care Medical Infusion Specialties at 769-233-8051 | | | | | | |
| Prescriber’s Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Product Substitution Permitted Date Dispense as Written Date | | | | | | |
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Version 1