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| HCM Logo REV5 COLOR | 625 S Pear Orchard Ridgeland, MS 39157Phone: 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  |
| CONFIDENTIALY STATEMENT: This communication and any attachments is intended for the use of the designated recipients named above and may contain information that is privileged, confidential, and exempt from disclosure under applicable law if the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please destroy all copies of this communication and notify the sender immediately by telephone. |

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