LINCOLN
Health System

OUTPATIENT INFUSION CENTER

Phone: 931-438-1100
Fax: 1-931-438-1219

General IV Order

Patient name: ______________________________ DOB: ______________ Sex :( ) Male ( ) Female

SSN:______________________ HT: __________ WT: __________ Allergies:_________________________________

Street Address____ City/State/Zip ______________________________

Home Phone #: ______________________ Work #: _______________________ Cell #: ______________________

Insurance Information:

Primary Insurance Name ______________________________________ Policy ID #: __________________________

Secondary Insurance Name______________________________________ Policy ID #:__________________________

Physician Information:

Physician's Name:________________________ Referral Contact Name: ____________________ Phone: ____________

Address:__________________________________City/State/Zip____

DEA#:________________________ NPI #:________________________ Fax #: ____________________________

State License #: ___________________________

Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description)____

Date of Diagnosis: _________________

Access: Does the patient have venous access? ☐Yes ☐ No If Yes, what type? ____

Orders:

*****Normal Saline will be used to clear all lines. All MEDIPORTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. *****

☐ **Do not administer Heparin to this patient.** ☐ **Insert PIV** ☐ **Insert PICC**

Physician's Signature ____**Date**_______________ **Time:**____________

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.