INTRATHECAL PUMP REFERRAL

pentec health
Large Enough to Serve Small Enough to Care

4 Creek Parkway
Boothwyn, PA 19061
Toll Free: 800-223-4376
Fax: (800) 355-1029

Office Contact: _____

Phone:_____**Fax:**_____

PATIENT INFORMATION:

Patient Name: _____**DOB:** _____

PLEASE ATTACH *OR* PROVIDE: Fax (800) 355-1029 *or* Pentec TDDSecure

- ☐ **Demographic Face Sheet ****Including:* Insurance Information & Emergency Contact
- ☐ **Telemetry** / Implant / IT Pump information
- ☐ **Clinical Note** with Allergies, Medications, and diagnosis code(s)
- ☐ **Prescription**
- ☐ **Patient Residence:** ☐ Home ☐ Inpatient Facility ☐ Hospice ☐ Nursing Home/Assisted Living

Facility/Hospice Name:_____

Contact: _____**Phone:** _____

NURSING ORDERS:

My signature authorizes nursing and pharmacy services in accordance with established policy and procedures including refill of the Intrathecal pump. Plan of Treatment will be submitted after the initial nursing assessment. I acknowledge that I will be periodically reviewing and signing the written Plan of Treatment in accordance with state regulation.

REFERRING PROVIDER:

Signature: _____**Date:**_____

Name & Title: _____

PRIMARY PROVIDER INFORMATION *(if not previously provided)*:

Name/Title: _____

NPI:_____DEA:_____License #: _____

Name of Practice: _____

Address:_____City:_____State:____Zip: _____

Phone(s):_____Fax:_____Email:_____

Preferred Communication Method: ☐ **Phone** ☐ **Email** ☐ **Fax**

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