# INTRATHECAL PUMP REFERRAL

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

**Office Contact:** ______________________________

**Phone:** ______________________________ **Fax:** __________

## PATIENT INFORMATION:

**Patient Name:** ______________________________ **DOB:** ________ **Alarm Date:** _______

## 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**