pentec health

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

INTRATHECAL PUMP REFERRAL

Date of Referral: _____
Referred By: _____
Office Contact: _____ Phone: _____

PATIENT INFORMATION:

Patient Name: _____ **DOB:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Gender: Male _____ **Female** _____ **Social Security Number:** _____
May Pentec Contact Patient?: Yes _____ **No** _____ **Height:** _____ **Weight:** _____
Diagnosis (es): _____
Allergies: _____

Emergency Contact or Guardian (if minor): _____
Relationship to Patient: _____ **Phone:** _____

Does the patient currently reside in a: ☐**SNF** ☐ **Rehabilitation Facility** ☐ **Other** _____
Is patient currently on hospice? ☐**Yes** ☐ **No** **Name of Facility/Hospice:** _____
Phone: _____ **Contact Information:** _____

INSURANCE INFORMATION:

Primary Plan Name: _____ **ID #:** _____ **Phone:** _____
Group #: _____ **Policy Holder/Subscriber:** _____ **DOB:** _____

Secondary Plan Name: _____ **ID #:** _____ **Phone:** _____
Group #: _____ **Policy Holder/Subscriber:** _____ **DOB:** _____

PROVIDER INFORMATION:

Preferred Communication Method: ☐**Phone** ☐**Email** ☐**Fax**
Doctor Name: _____ **NPI:** _____ **DEA:** _____ **License #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Fax:** _____ **Email:** _____

PUMP INFORMATION:

Pump Type: ☐**Codman** ☐**Prometra** ☐**Synchromed II** ☐**Other** _____
Reservoir Capacity: _____ **Alarm Date:** _____ **Date Pump Implanted:** _____

PROGRAMMED SETTINGS:

Infusion Mode: _____

PLEASE ATTACH SIGNED PRESCRIPTION, IMPLANT RECORD, PROGRESS NOTES, TELEMETRY, AND HISTORY & PHYSICAL

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.

Provider Signature: _____ **Date:** _____

TO ENSURE TIMELY PROCESSING, PLEASE COMPLETE & ATTACH ALL INFORMATION.

REFERRAL INSTRUCTIONS

Please note that a complete referral is required for faster processing by our Client Services team. For your convenience, some items may be attached to the referral form by simply writing "see attached" in the appropriate section of the form. A complete referral should contain the following items:

- Office Contact Person (including phone and email)
- Patient Demographic Information
  (including address, social security number, and date of birth).
- Patient Diagnosis Code(s) (related to the IT pump)
- Patient (or Caregiver) Contact Information
- Requested Place of Service (if in a facility or under hospice care, please provide contact information)
- IT Pump Information (including next alarm date and implant note)
- Provider Information (including a signature on the referral form)
- Insurance Information (including any secondary or tertiary plans)
- Telemetry Printout (even if additional office refills are planned)
- Most Recent Clinical Notes (may be necessary for insurance authorization)

A member of our Client Services team will notify you if any items are needed to complete the referral process. Thank you for choosing Pentec Health to provide intrathecal pump management services for your patient.

Please contact Pentec Health at 800-223-4376 and ask for a member of our Specialty Infusions Client Services team if you have any questions.