PURE INFUSION SUITES

GENERAL ORDER

Fax form to:
Billings - 406.206.0105
Great Falls - 406.794.0555
Boise - 208.545.3214
Colorado Springs - 719.623.0085
Grand Junction - 970.404.8100

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis:

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B results.**

*ICD 10 CODE

*** Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.**

- [ ] Drug
- [ ] Dose
- [ ] Frequency
- [ ] Refills

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date

Provider Phone | Provider Fax

Special needs/notes: