Lincoln Medical Center

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.