

| TPN Referral Form | | | |
|---|--|---------------------------------------|--------------------------|
| To | | From | |
| Name of Practice/Facility | | Phone | Fax |
| Intake Phone | | Number of Pages including Cover | |
| Date | | Home Phone | |
| Patient Name | | Date of Birth | |
| Patient Home Address | | City | State Zip |
| Diagnosis | | Gender | M F |
| Are TPN Orders attached to this Referral Form? Y N | | First Dose? Y N | |
| Patient Eating? Y N | | Estimated Length of Therapy | |
| IV Access PICC Port Central Other: | | Y N | |
| Hospital Discharge Summary attached? Y N | | Most Recent Labs (date) Attached | |
| Start of Care Date | | Spanish-speaking Only | |
| History & Physical Attached | Marital Status S D W M | Diabetic? Y N | |
| HT | WT | Allergies | |
| Other home health care needs? | | | |
| Physician signing discharge orders | | Fax | Phone |
| Physician who will follow patient at home (if different than above) | | | |
| Physician Name | | Fax | Phone |
| Patient Demographics Attached | Delivery Address (if different than home) | | |
| Patient Cell Number | | Patient Work Number | |
| Emergency Contact Outside Home | | Relationship | Phone |
| Caregiver Name | | Caregiver Teachable? Y N | Phone |
| Patient Independent? Y N | | Patient Teachable? Y N | Homebound? Y N |
| Insurance | | ID# | Phone |
| Medi-Cal ID# | | Issue Date | |

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.