promptcare™

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General Therapy Order Form

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

● Copy of insurance card ● Patient demographics ● History and physical ● Pertinent labs and test results based on therapy

2. Patient Information:

☐ Male ☐ Female Height: _____ ☐ in ☐ cm Weight: _____ ☐ lbs ☐ kg ☐ NKDA Allergies: _____

Is this the first dose? ☐ Yes ☐ No, date of last dose: _____ Next due: _____

3. Diagnosis and Clinical Information:

ICD-10 (required): _____ Primary diagnosis: _____ Other information: _____

4. Prescription Information:

Medication	Medication: _____ Strength/formulation: _____
Dose / Frequency	Dose: _____ Frequency: _____
Directions	
Quantity / Refills	☒ Dispense 1 month supply / QS on all selected medications / Refill x 12 months Dispense all medical supplies necessary ☐ Other: _____

5. Other Orders:

6. Prescriber Information:

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License #: _____ DEA #: _____ NPI: _____

_____ _____ _____ _____

Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.