

## 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:**

<b>Medication</b>	Medication: _____ Strength/formulation: _____
<b>Dose / Frequency</b>	Dose: _____ Frequency: _____
<b>Directions</b>	
<b>Quantity / Refills</b>	<input checked="" type="checkbox"/> Dispense 1 month supply / QS on all selected medications / Refill x 12 months Dispense all medical supplies necessary <input type="checkbox"/> Other: _____

**5. Other Orders:**

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**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.

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.