

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	<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:**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.

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