REVITALIZE
INFUSION CENTER

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis: _____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes
- Required Information:
  - If PICC line, please provide a copy of the insertion note

Height: _____

Weight: _____

Orders:

Central Venous Access

☐ Perform PICC line care per protocol weekly and as needed

☐ Perform Port maintenance per protocol

Frequency: ☐ weekly ☐monthly ☐ as needed

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus