Walgreens Home Infusion services

START INFORMATION	3915 W. SAGINAW HWY LANSING, MI 48917 PH# 517-323-3848 FX# 517-323-3767	Referral Date:
Date & Time:		

YOUR NAME:	Phone: Fax:

DEMOGRAPHIC INFORMATION

PATIENT Name:	**SSN:**	**Allergies:** ❒ NKA	**DNR Status** ❒ DNR Received ❒ N/A **Other Advanced Directives:** ❒ Yes ❒ No
Address:	**DOB:** ❒ Immunizations up to date	**Diabetic:** ❒Yes ❒ No ❒Insulin Dependent	
HOME Phone: **CELL PHONE:**	❒F ❒M Ht:_____ Wt:_____	**Infectious Disease Status:** ❒ TB ❒ PPD neg. Date:_____ ❒ CXR Date:_____ ❒ MRSA ❒ VRE ❒ Other	
INSURANCE INFO:			

PLAN NAME:	*CONTRACT #*	*GRP #*
PLAN NAME:	*CONTRACT #*	*GRP#*

THERAPY INFORMATION

Primary Diagnosis		ICD-9:
Secondary Diagnosis		ICD-9:
Significant History/ Problems		
Medications First Dose: ❒Y ❒N	Duration:	Start/Stop: Time of Last Dose:
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PLEASE LIST FACILITY WHERE IV ACCESS WILL BE PLACED AND THEIR PHONE NUMBER:		
Type of Access Device:	No. of Lumens:	Date /Time/Place Inserted:
Lab Work Orders:		

MEDICAL CARE

Physician Name:	PHONE: FAX:
NURSING AGENCY:	PHONE: FAX: