



MRN: _____
DOB: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Guidelines for Prescribing Hydration
(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

- ___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)
- ___ Include patient demographic information and insurance information. (Copy of insurance cards if available)
- ___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**
- ___ Other as requested: _____

Pre-Screening:

- ___ CMP lab results (as available)
- ___ Clinical lab monitoring may be required for orders of hydration with certain additives

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.