PALMETTO INFUSION SERVICES
INTAKE INFORMATION

☐ HOME AIC SITE:_____	SERVICE LEVEL
Advance Directive in place ___Yes ___NO DNR ___Yes ___NO	

REF #	
MRN	

NURSE: COLA CHAS CON FLO GV BF AIK	PRIMARY NURSE:

REF DATE	START DATE	REFERRAL TAKEN BY	HOSP/ROOM #	REF. CONTACT: at
LAST NAME		FIRST NAME	MI	PHONE #
STREET ADDRESS		CITY	STATE	ZIP
MAILING ADDRESS (If different than street address above)		CITY	STATE	ZIP
DOB / /	AGE	SEX M/F	SS#	COUNTY
HOME PHONE		ALTERNATE PHONE		
INSURANCE # 1		PHONE #		INSURED NAME & DOB
POLICY #		GROUP #		EMPLOYER NAME & PHONE #
INSURANCE # 2		PHONE #		INSURED NAME & DOB
POLICY #		GROUP #		EMPLOYER NAME & PHONE #
EMERGENCY CONTACT		RELATIONSHIP		PHONE

DIAGNOSIS/ ICD-9		
THERAPY AB – TPN – CHEMO – PM – FL – CC – ENT – RCADE – INJECT – OTH _____		ALLERGIES
SCRIPT		
ANTICIPATED DURATION		LINE INFO - TYPE
LAB ORDERS	DIABETIC Y/ N NA RESTRICTED Y/ N	HT / WT

ORDERING PHYSICIAN	STREET ADDRESS		CITY	STATE ZIP
PHONE #	FAX #	UPIN #	NPI#	LIC #
NURSING AGENCY	PHONE #		CONTACT	

☐ NO AGENCY

Revised 07/26/07