TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

Infusion Order Form

RETURN COMPLETED FORM VIA FAX TO:
888.898.9113

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is this a new Talis Healthcare Patient?	☐ Yes	☐ No

Order date:	Weight: kg lbs	Height: m in
Drug allergies:	☐NKDA	☐YES. Please specify.

ICD-10 diagnoses:		

SUPPORTING DIAGNOSTIC AND LABORATORY DATA		
☐ CBC	☐ BMP	☐ Serologies
Other:		

MEDICATION			
Name	**Dose**	**Frequency**	**Refills**

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Thank you for choosing Talis Healthcare

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