



121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
 Proudly serving over 30 years

Date: _____
 NEW PATIENT
 CURRENT PATIENT



Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 ICD-10 Code _____ Diagnosis _____ Allergies _____
 Diabetic Yes No Results _____ Insulin Dependent Yes No Date of next blood work _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
 Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

	Anti-Infective Therapy 1	Anti-Infective Therapy 2
Therapy Ordered	<input type="checkbox"/> Vancomycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Cefepime <input type="checkbox"/> Daptomycin <input type="checkbox"/> Ertapenem <input type="checkbox"/> Ceftolozane / tazobactam <input type="checkbox"/> Other: _____	<input type="checkbox"/> Vancomycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Cefepime <input type="checkbox"/> Daptomycin <input type="checkbox"/> Ertapenem <input type="checkbox"/> Ceftolozane / tazobactam <input type="checkbox"/> Other: _____
Services Ordered	<input type="checkbox"/> Pharmacy only <input type="checkbox"/> Home Health <input type="checkbox"/> Nursing/HHA Name: _____	
Flushing	<input type="checkbox"/> NS 5 ml SASH and prn <input type="checkbox"/> Heparin 20 units <input type="checkbox"/> Heparin 100 units SASH and prn	Is patient Homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No Access: None <input type="checkbox"/> or Type: _____ Date inserted: _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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