

IV Phone: (956) 994-1044



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Fred's Pharmacy

Intake / Referral Form

3001 N 23rd STE.9
McAllen TX 78501

DME Phone:(956) 994-0767



DME Fax: (956) 994-0989

Referred Date:		Referral Source:		Phone:		Order Date:	
PATIENT NAME:				D.O.B.:		MALE FEMALE	
AGE:		Pt's Ht:	Pt's Wt:	Patient's Principle Language:			
PATIENT'S PHONE:			ADDRESS:				
CITY:		STATE:			ZIP:		
DIRECTIONS FOR PATIENTS / CLIENTS LOCATION: _____ _____ _____							
NAME OF PRIMARY CAREGIVER:				PHONE:			
EMERGENCY CONTACT:				PHONE:			
PATIENT ALLERGIES:							
PRIMARY DIAGNOSIS:				SECONDARY DIAGNOSIS:			
PERTINENT MEDICAL HISTORY and / or TEST RESULTS:						See Attached Orders / Forms: YES / NO	
LEGAL DOCUMENTATION:		ADVANCE DIRECTIVES		LIVING WILL		SPECIAL REQUESTS	
INFECTIOUS PROCESS:				DISCHARGE DATES FROM CARE FACILITIES:			
DATE HOME IV THERAPY INITIATED:				ESTIMATED DURATION OF THERAPY (DAYS/WEEKS):			
IV TREATMENT:		PERIPHERAL		CENTRAL		PORTACATH PICC LINE	
EQUIPMENT, SUPPLIES OR SERVICE NEEDED:							
PAYOR:		INSURANCE		MEDICAID		MEDICAID PENDING PRIVATE PAY	
MEDICARE #:				MEDICAID #:			
INSURANCE NAME: _____		POLICY #: _____		GROUP#: _____			
ADDRESS: _____		CITY: _____		STATE: _____		ZIP: _____	
TELEPHONE #: _____				FAX: _____			
PRIVATE PAY AMOUNT \$:				BILL TO:			
DOCTOR'S NAME: _____		TELEPHONE #: _____		FAX #: _____			
ADDRESS: _____		CITY: _____		ZIP CODE: _____			
TAKEN BY:							