Date: _____

Patient Infusion Demographic Sheet

Please fax this completed form, the infusion order signed by the doctor, the last office note, and labs (if not done at EAMC) to 334.528.1510

Name: _____ **Preferred Name:** _____

DOB: _____ **Race:** _____ **S.S.#:** _____

Address:_____ **City, St., Zip:** _____

Cell #: _____ **Work/Home #:** _____

Email: _____

Emergency Contact (Name and #): _____

Primary Ins: _____
Policy ID #: _____
Group #: _____
Policy Holder:_____

Secondary Ins: _____
Policy ID #: _____
Group #: _____
Policy Holder: _____

Doctor ordering the infusion: _____

Drug to be infused:_____ **Diagnosis:**_____

Dosage:_____ Frequency:_____

Is patient covered under a COPAY or OTHER Assistance program? **YES** **NO**

If yes, name of program and fax number: _____

Contact person name and number: _____ Reference number: _____

****PRIOR AUTHORIZTION/CERTIFICATION:** Not Required Required

If Required, the PA number is : _____

PA Effective dates: From:_____ To: _____

☐ **I certify that the patient has been educated on the drug to be infused.**
(We cannot infuse until patient has been educated on the drug and understands what the drug is treating.)

Office Staff member filling out form: _____

**This form must be completed in full and required material faxed before we can schedule any new infusion.

EAMC STAFF ONLY: ****INFUSION DATE AND TIME: _____

Notes: _____