TDD HOME NURSING PATIENT REFERRAL

TO ENSURE TIMELY PROCESSING, PLEASE COMPLETE & ATTACH ALL ADDITIONAL DOCUMENTATION WITH COMPLETED REFERRAL FORM.

- ☐ Copy of Insurance Cards (Front and back of card, including any secondary or tertiary plans)
- ☐ Copy of Demographic Information
- ☐ History & Physical With ICD-10 Codes
- ☐ Pump Implant Record
- ☐ Copy of Most Recent Telemetry/Pump Printout
- ☐ Signed Prescription if Patient Is Due for Refill (ERx)

PATIENT & REFERRING PHYSICIAN INFORMATION:

Date of Referral: _____

Patient Full Name: _____ DOB: _____ Gender: Select Optio

Patient Address: _____ Patient Phone: _____

Emergency Contact/Guardian (if minor): _____ Phone: _____

Relationship to Patient: _____ Diagnosis(es) & ICD-10 Codes Related to TDD Therapy: _____

Is Patient Aware They Have Been Referred to Home Nursing Services? ☐ Yes ☐ No

Patient Currently Resides in a: Select Option Other: _____

Is Patient Currently Part of a TDD-related Clinical Trial? ☐ Yes ☐ No

Is Patient Currently on Hospice? ☐ Yes* ☐ No *If Yes, Name of Facility/Hospice: _____

Facility/Hospice Phone: _____ Facility/Hospice Contact: _____

Is This a WC Patient? ☐ Yes† ☐ No †If Yes, Adjuster's Name and Phone: _____

Managing Pump Physician's Name and Practice Name: _____

Practice Phone Number: _____

DEA: _____ NPI: _____

PUMP INFORMATION: MUST BE COMPLETED BELOW

Pump Type: _____ Other: _____

Alarm Date: _____ Pump Implant Date: _____ Date of Last Refill: _____

PUMP MEDICATION INFORMATION: (This information is not a prescription)

List all medications, concentrations, and total volume required:

_____

Total Volume Required: _____ mL

INSURANCE INFORMATION or COPY OF INSURANCE CARD:

Primary Plan Name: _____ ID #: _____

Group #: _____ Policy Holder/Subscriber: _____ DOB: _____

Relationship to the Patient: _____ Phone Number (on ID card): _____

Secondary Plan Name: _____ ID #: _____ Phone: _____

NURSING ORDERS:

My signature authorizes nursing and pharmacy services in accordance with established policy and procedures including refill of the implanted intrathecal pump. I certify that home nursing services and the compounded preparation to infuse continuously at home via implanted pump is clinically/medically necessary for the patient. Plan of Treatment will be submitted after the initial nursing assessment. I acknowledge that I will be periodically reviewing and signing the written Plan of Treatment in accordance with state regulation.

Provider Signature: _____ Date: _____