Insurance Verification

Name: Queonise Campbell DOB: 4/9/90 MR# 7056095
Ins. ID # 110701081
Phone#: 816-247-5678
Date: 9/27/17 Time: 10:57 DX: F31.9
Eff Date: 2/1/17
Copay: 0 DED: 0
Percent: 100 OOP: 0
Name of Person: Manny
REF: # Manny A. 10:58am 9/27/17
Jcode: J2680 Prolixin-Decanoate

Auth Req'd YES: _____ NO: ✓
Auth# _____ Date Span: _____
Phone: _____ Fax: _____
Name: _____

Can we Buy and Bill:
YES: _____ NO: _____
Specialty Pharmacy: _____
Phone#: _____ Fax: _____

OUTPATIENT INFUSION CENTER
ORANGE REGIONAL MEDICAL CENTER
NEW PATIENT INTAKE FORM
(MUST BE USED EVERYTOME A NEW PATIENT IS TO BE SCHEDULED)

NAME: Quenoise Campbell (MR 705095)

DOB: 4/9/90 Mrs. Campbell

PT'S PHONE #: 845-591-1035 (mother)

PROCEDURE: ~~Aripiprazol~~ Prolixin-Decanoate 9/28/17 11:30

DURATION:

DIAGNOSIS: Schizo - Bipolar

NAME OF PERSON TALKED TOO: Sharon Seidel

PHYSIAN & PHONE:

INSURANCE: Medicaid

ALLERGIES:

IMMEDIATELY AFTER MAKING THE APPOINTMENT, FAX THIS FORM AND COPY OF SCRIPT FOR AUTHORIZATION AND PRE-REGISTRATION PROCESS: **EXT 1715**

*PLEASE SEND A COPY TO PHARMACY IF PATIENT IS TO RECEIVE CHEMOTHERAPY: **EXT 1124**

STACY BUDD
PHONE: (845) 333-1905
FAX: (845) 333-1902

ALLISON ROCHE
PHONE: (845) 333-1906
FAX: (845) 333-1902

ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

DO NOT USE ABBREVIATIONS

U	MS	SC	QOD	QD	µg
IU	MSO_4	$MgSO_4$	SQ	SL	

Patient Label

Date & Time	
9/26/17	PATIENT: CAMPBELL, QUENDISE MR# 705095 Rx PROLIXIN DECANOATE 50mg IM q 2 weeks NEXT DOSE 9/27/17

DX:

CESAR A. ROJAS, MD
LIC. A77700-1
DEA# BR9705344
NPI# 1922640735

"Medications will be dispensed in accordance with the hospital formulary system"

Prescriber Signature: _____ Print Name: _____ Date/Time: _____

Nurse Signature: _____ Print Name: _____ Date/Time: _____

☐ T.O. RBV Fax to Pharmacy ☐ Time Faxed: _____