



WWW.VASCOINFUSION.COM  
 PH: 602-346-0204 FAX: 877-637-6691

- New Referral   
  Restart   
  Medication/ Order Change (New Order Required)   
  Benefits Verification Only   
  D/C Infusions \*indicate name of drug(s)

*Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.*

**PATIENT INFORMATION**

**PHYSICIAN INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 DOB: \_\_\_\_\_ SS# \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Email: \_\_\_\_\_

Referring Physician: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_  
 Contact Phone # \_\_\_\_\_ Contact Fax # \_\_\_\_\_  
 NPI / TIN: \_\_\_\_\_

**NEULASTA MEDICATION ORDERS**

Patient Weight: \_\_\_\_\_ kg   
 Dosing:  6 mg SQ \_\_\_\_\_ weeks  
 Other \_\_\_\_\_

Refills: \_\_\_\_\_

**INDICATION/DIAGNOSIS**

**NOTES (ADDITIONAL INFO)**

- Leukocyte growth factor  
 Other

**\*ICD-10 required**

\_\_\_\_\_  
 Referring Physician's Signature                      Date

**REQUIRED DOCUMENTATION**

- Recent Office notes (along with any therapies tried and outcomes)   
  Current Medication List   
  History and Physical Report  
 Lab Results   
  Insurance Cards (front and back)   
  Demographic Sheet

**ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)**

- HepB Surf Ag (w/in 12 months)   
  HepB Core Ab (w/in 12 months)   
  PPD Results (w/in 12 months)  
 Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

**APPOINTMENT DATE & TIME:** \_\_\_\_\_

**FOR OFFICE USE ONLY**