DIXIE Vital Care
Infusion Pharmacy Services

Referral Form

DIXIE INFUSION PHARMACY,
DBA Dixie Vital Care
311 Landrum Pl. Suite 600
Clarksville, TN 37043 - 6319
Tel: 931-241-5655
Fax: 931-241-5654

Patient Information

Last Name	First Name	SSN	DOB
Home Address	City	State	Zip
Home Phone	Work Phone	Parent/Guardian	
Shipping Address	City	State	Zip

Pharmacy Insurance Information

Primary Insurance:	Rx Bin:	Secondary Insurance:	Rx Bin:
ID Number:	Group Number:	ID Number:	Group Number:

Physician Information

Prescriber Name:	Licence:	DEA:			Office Contact:
Address:	City:	State:	Zip:	Phone:	Fax:

Diagnoses Information

Primary Dx:	ICD-9:	Secondary Dx:	ICD-9:

Medications *(You may tape Prescriptions here prior to faxing)*

Immunosuppressants

Medication	Strength	Directions	Quantity	Refills
☐ Prograf				
☐ Gengraf				
☐ Neoral				
☐ Sandimmune				
☐ Cellcept				
☐ Myfortic				
☐				

Corticosteroids

Medication	Strength	Directions	Quantity	Refills
☐ Prednisone				
☐				

Antivirals

Medication	Strength	Directions	Quantity	Refills
☐ Acyclovir				
☐ Gancyclovir				
☐ Valcyte				
☐				

Antibiotics

Medication	Strength	Directions	Quantity	Refills
☐ Septra/Bactrim	SS			
☐				

Antifungals

Medication	Strength	Directions	Quantity	Refills
☐ Noxafil				
☐ Nystatin Susp				
☐ Mycelex Troche				
☐ Nystatin Vaginal				
☐				
☐				

Gastric Agents

Medication	Strength	Directions	Quantity	Refills
☐ Pepcid				
☐ Tagamet				
☐ Zantac				
☐ Protonix				
☐ Prilosec				
☐ Nexium				
☐				

Hypertension Agents

Medication	Strength	Directions	Quantity	Refills
☐ Metoprolol				
☐ Labetalol				
☐ Norvasc				
☐ Diltiazem				
☐				

Additional Medications

Medication	Strength	Directions	Quantity	Refills
☐ Citracal +D				
☐ Colace				
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				

☑ **All orders are sent with a BP Cuff, Thermometer, Pill Cutter, and Pill Box**

Delivery Information

Today's Date:	Needed by:	Deliver to: ☐ Patient's Home ☐ MD Office/Clinic ☐ Patient's Work ☐ Other:

Prescriber Information

Physician: _____

Contact Name: _____ Phone #: _____ Fax #: _____ NPI #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

I authorize Dixie Vital Care and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature: _____ DEA #: _____ Date _____