LUX INFUSION
HEALTH. TEAM. EXCELLENCE

Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight:
Patient Status: New to therapy Continuing therapy	Next due date *(if applicable):*

2. PHYSICIAN INFORMATION

Physician's Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State:	Zip:
Office contact:		Email:	
Office phone:		Office fax:	

3. DIAGNOSIS INFORMATION *(and year of diagnosis)*

ICD 10 (_______) Other *(specify)*: ____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION *(requires new order every 12 months)*

Vital signs per LUX Protocol
Anaphylaxis & Hydration Management per Lux Protocol

6. SIGNATURE *(required)*

______________________________ ______________________________
PHYSICIAN'S SIGNATURE DATE

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