i-PORT ADVANCE™ injection port

PRESCRIPTION FORM

Fax to: _____

Date: _____

PATIENT INFORMATION

Patient's name:	DOB:
Address:	City, state, zip:
Home phone:	Email address:

If patient is under 18 years of age:

Parent/guardian name: _____

Primary insurance: _____

The patient is currently under my care for management of:

☐ Diabetes mellitus ☐ Other _____

PRESCRIPTION

Diagnosis Code (ICD-10): ☐ E11.9 ☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ Other _____

In order to continue with this treatment, I am prescribing the supplies listed below. This prescription may be refilled as necessary for one year.

i-Port Advance™ injection port: Patient ordered to change every 3 days, or as listed: _____

PRESCRIBING DOCTOR INFORMATION

Doctor's name:	Phone:	Fax:
License#:	Address:	
NPI#:	City, state, zip:	

X _____ Date: _____

***Substitute Prescriber:** If you are another authorized prescriber signing on behalf of the prescriber identified on this form, you certify that you are a member of the same clinical practice, have the authority to sign on his/her behalf under specified circumstances (vacation, illness, leave, etc.), have access to this patients file , and approve this order by signing here:

X _____ Date: _____

Medtronic