Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

ThrIVewell INFUSION

Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

ORDER FORM SUBLOCADE®

Date: ____________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION	
Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

SUBLOCADE*:

(SELECT ***ONE*** *OF THE FOLLOWING)*

____ Dosing: 2 patches of 8% capsaicin (640 mcg per cm2) every 3 months

____ Dosing: 3 patches of 8% capsaicin (640 mcg per cm2) every 3 months

____ Dosing: 4 patches of 8% capsaicin (640 mcg per cm2) every 3 months

Physician Signature ______________________________ **Date (Order is Valid for One Year)**____________________

REQUIRED DIAGNOSIS:

______ Neuropathic pain associated with postehrpetic neuralgia (PHN)

_____ Neuropathic pain associated with diabetic peripheral neuropathy (DPN)

_____ Other_________________________

Last Infusion/Injection Date: ________________________

REQUIRED DOCUMENTATION CHECKLIST:

______ Patient Demographics

______ Insurance Card/Information

______Clinical/Progress Notes supporting DX

______Current Medication List and H&P

______Capsaicin 8% Topical System Procedure Notes

STANDING LAB ORDERS (to be drawn at clinic): _____ CMP _____ CBC *Frequency_________________________

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** ____ Date ______________

Provider ________________________ Phone ____________ Fax ______________