

INFUSION THERAPY REFERRAL FORM

<p>Please completely fill out this form: Fax: (503) 215-8435 Phone: (503) 215-4633 or (800) 772-7053</p>	
Today's Date / Time:	
Referral Source:	Name: Click or tap here to enter text. Phone: Click or tap here to enter text. Fax: Click or tap here to enter text.
Patient Name:	Click or tap here to enter text.
DOB:	Click or tap here to enter text.
SSN:	Click or tap here to enter text.
Insurance Information: <input type="checkbox"/> Faxed	Insurance Company: Click or tap here to enter text. ID/Policy#: Click or tap here to enter text. Subscriber: Click or tap here to enter text.
Demographic Page: <input type="checkbox"/> Faxed	Address: Click or tap here to enter text. Phone Number: Click or tap here to enter text.
Ordering/Following Physician:	Name: Click or tap here to enter text. NPI/Tax ID: Click or tap here to enter text. Phone: Click or tap here to enter text. Fax: Click or tap here to enter text.
Medication Ordered: <i>(Drug, Dose, Frequency, Duration)</i> <input type="checkbox"/> Orders Faxed	Click or tap here to enter text.
Labs Ordered: <input type="checkbox"/> Orders Faxed	Click or tap here to enter text.
Diagnosis for Therapy:	Click or tap here to enter text.
Diagnosis Code:	Click or tap here to enter text.
Anticipated Start of Care:	Click or tap here to enter text.
Allergies:	Click or tap here to enter text.
Type of Central Line: <input type="checkbox"/> Faxed Record of Central Line Insertion	Click or tap here to enter text.
X-Ray Verification of Tip Placement: <input type="checkbox"/> Faxed	Click or tap here to enter text.
History & Physical <input type="checkbox"/> Faxed	
Ordering Physician Signature	
Additional notes/comments:	Click or tap here to enter text.