SPECIALTY INFUSION CENTERS

FAX 800-540-1852 | PHONE 212-776-9090 | REFERRAL@SPECIALTYINFUSION.COM

GENERAL REFERRAL FORM

Please fax the completed form along with patient's insurance card and supporting clinicals.

Locations: ☐ **Manhattan** ☐ **Long Island** ☐ **Bronx** ☐ **Staten Island** ☐ **New Paltz** ☐ **Harrison**

Patient Information

Patient Name _____ DOB _____

Addresss _____ Email _____

City, State, Zip Code _____ Preferred Phone _____

Prescriber Information

Prescriber's Name _____ Practicer Group _____

State License# _____ Address _____

NPI# _____ City, State, Zip Code _____

Contact Name _____ Phone _____

Contact Email _____ Fax _____

Insurance Information (please fax/email insurance card if available)

Primary Payer _____ Secondary Payer _____

ID# _____ ID# _____

Subscriber Name _____ Subscriber Name _____

DOB _____ DOB _____

Diagnosis and Clinical Information

ICD Code _____ Date of Diagnosis _____ Special Instructions? ☐ Yes ☐ No _____

Name of Diagnosis _____ Failed Prior Treatments? ☐ Yes ☐ No

Continuation Therapy? ☐ Yes ☐ No Start Date _____ If yes, Drugs _____

Weight _____ Height _____ TB/PPD Status _____ Date _____

Allergies _____ **Please fax a complete list of current & failed medications**

Prescription Information

Medication _____ Refills _____ Route of Admin. ☐ IV ☐ Injection

Dose/Strength _____ Frequency _____ Length/Date Range _____

Induction? ☐ Yes ☐ No Premeds with Dose _____

Directions _____

Labs

Panel: ☐ CBC with Diff ☐ CBC w/out Diff ☐ CMP ☐ Hepatic function ☐ CRP ☐ ESR ☐ Other _____

Frequency: ☐ With Each Dose ☐ Every 8-12 weeks ☐ Every 6 weeks ☐ Other _____

Physician Signature Required

_____ ☐ Patient is interested in patient support programs

Dispense as written Date