



FAX 800-540-1852 | PHONE 212-2INFUSE (212-246-3873) | REFERRAL@SPECIALTYINFUSION.COM

GENERAL REFERRAL FORM

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

- Locations: Manhattan Bronx Staten Island New Paltz W. Harrison
 Port Jefferson Station Syosset

Patient Information

Patient Name _____ DOB _____
 Address _____ 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