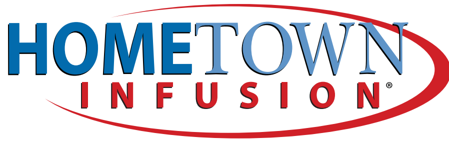

General Infusion Referral Form

(Complete and Fax to: 586-323-8283)

Centralized Intake
Phone: 866-323-8200
Fax: 586-323-8283

Patient Information

Patient Name: ______
DOB: ______
Gender: ☐ Female ☐ Male SSN: ______
Wt: ______ ☐ kg ☐ lbs Ht: ______ ☐ cm ☐ in
Address: ______
Apt/Suite: ______
City: ______ State: ______ Zip: ______
Phone: ______ Alternate: ______
Insurance Plan: ______ Plan ID: ______
Subscriber Name: ______

Prescriber Information

Prescriber Name: ______
NPI: ______
Address: ______
Apt/Suite: ______
City: ______ State: ______ Zip: ______
Contact: ______
Phone: ______
Fax: ______

Thank you for your referral!

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis Code (ICD-10): ______ Date of Diagnosis: ______
Access: ☐ Peripheral ☐ PICC ☐ Implanted Port ☐ Other: ______ Date of Last Infusion: ______ Date of Next Infusion: ______
Negative TB Test: ☐ Yes ☐ No Date of Test: ______ Hepatitis Screening: ☐ Yes ☐ No Date of Test: ______ Immunizations Current: ☐ Yes ☐ No

Prior Therapy: ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: ______
Concomitant Medications: ______
Allergies: ☐ NKDA ☐ Other: ______

Prescription

Medication:	Directions: ☐ Custom (complete details here) ☐ See Dose box below	Refills:
Dose Instructions:	Dose: ______ mg/kg or Total Dose: ______ mg Frequency: ______ Directions: ______ Quantity: ______ Administration Rate: ☐ Per manufacturer guidelines, as tolerated ☐ ______	
Desired Start Date:	Lab Order: ______ (Labs will only be drawn in the home on day of regularly scheduled nursing visit) Pre-Medication Orders: ______ Anaphylaxis Response Kit per HTI Protocol: ☐ Yes ☐ No	

Medication administration and IV access maintenance procedures to be followed per HomeTown Infusion pharmacy protocol.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: ______

Stamp signature not allowed, physician signature required.

Prescriber's Signature: ______ Date: ______

I authorize HomeTown Infusion and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to HomeTown Infusion.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 866-323-8200.