emerging HEALTH

Home infusion referral form

Section 1: Referring provider

Facility		
Referrer name	Referrer phone	Referrer email

Section 2: Patient information (Please complete or attach patient demographics.)

First name	Last name		Room #
Patient address			
City	State		ZIP
Phone	Date of birth	Gender	Primary language
Alternate address			Alternate phone

Section 3: Insurance coverage (Please complete or attach a copy of the front and back of patient's insurance card.)

Primary insurance (if applicable)	Primary plan ID no. (if applicable)
Secondary insurance (if applicable)	Secondary plan ID no. (if applicable)
Tertiary insurance (if applicable)	Tertiary plan ID no. (if applicable)

Section 4: Clinical information

Line type	# Lumens	Diabetic: ☐ Yes ☐ No
Weight ☐ Kg ☐ Lb	Date line placed	DNR status: ☐ Yes ☐ No
Height ☐ in ☐ cm	IV Line Verified via CXR: ☐ Yes ☐ No	Medicare homebound status: ☐ Yes ☐ No
Transplant? ☐ NA ☐ Pre ☐ Post	Transplant organ	Transplant location
Allergies		
Home health needs: ☐ Yes ☐ No		
Nursing agency name		Nursing agency phone

Therapy one		
Primary diagnosis/ICD 10	Drug name	Length of therapy
Req start date	Ordering MD	Ordering MD phone
Dose	Following MD	Following MD phone
Frequency	Dosing times	First dose administered? ☐ Yes ☐ No

Therapy two (if applicable)		
Primary diagnosis/ICD 10	Drug name	Length of therapy
Req start date	Ordering MD	Ordering MD phone
Dose	Following MD	Following MD phone
Frequency	Dosing times	First dose administered? ☐ Yes ☐ No

Fax completed forms to 877-290-2050.
Questions? Call us at 877-290-2040.