# Physician Infusions General Referral Form

## Patient Information

Patient Name: DOB: Phone: Height: Weight:

Address: Email:

## Insurance Information (Include a copy of the front and back of patient's insurance card)

*Primary Insurance:*

Policy #: Group #: Ins Phone:

*Secondary Insurance:*

Policy #: Group #: Ins Phone:

## Referring Provider Office Information

Provider Name: NPI: Office Name:

Office Address:

Office Contact: Phone: Fax: Email:

## Prescription

Medication: Dose: Frequency: Route: IV Refills:

Diagnosis Code: Diagnosis Description:

Allergies: First Infusion? Y/N Last Infusion Date (If applicable):

☐ Provide nursing care per Physician Infusions policies and procedures, including but not limited to post-infusion observation and management of adverse reactions.

## Special Instructions

*Physician Infusions will choose the product/biosimilar medication based on payor requirements, availability, and clinical indication.*

*Please send completed referral form, office notes, labs/imaging results (including TB results and date) to Physician Infusions fax (512) 354-4938.*

Prescriber Signature: _____ Prescriber Printed Name: _____ Date:_____