

General Referral Order

Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): _____ ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

Center will use Hypersensitivity protocol established by Infuse One Ohio

Other: _____

PRE-MEDICATION ORDERS

Diphenhydramine 25mg / 50mg PO / IV

Acetaminophen 325mg / 500mg / 650mg PO

Other: _____

Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

Medication: _____

Route: intravenous subcutaneous intramuscular

Dose: _____

Frequency: _____

Duration: _____

Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) _____ Provider Signature _____ Date _____

Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.