REFERRAL FORM

Mission Infectious Disease
& Infusion Consultants

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PATIENT NAME: _____ **DOB:** _____

PRIMARY DIAGNOSES: _____

PMH/SECONDARY DIAGNOSES: _____

ALLERGIES: _____ **HT:** _____ **WT:** _____

PATIENT PHONE NUMBER: _____ **PATIENT SSN:** _____

PATIENT HOME ADDRESS: _____

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

PRIMARY INSURANCE: _____ **POLICY NUMBER:** _____ **GROUP ID:** _____

SECONDARY INSURANCE: _____ **POLICY NUMBER:** _____ **GROUP ID:** _____

REFERRING PHYSICIAN/FACILITY: _____ **PHONE NUMBER:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE NUMBER:** _____

PLEASE INDICATE MEDICATION ORDERED:

☐ Ceftriaxone (Rocephin)	☐ Dalvance	☐ Solumedrol	☐ Prolia
☐ Daptomycin (Cubicin)	☐ Telavancin (VIBATIV)	☐ Reclast	
☐ Ertapenem (Invanz)	☐ Tigecycline (Tygacil)	☐ IVIG	
☐ Vancomycin	☐ Gentamicin	☐ Remicade	

☐ Other: _____

PLEASE INCLUDE ANY OTHER PERTINENT PATIENT INFORMATION (H&P, MEDICATION LIST, CLINICAL NOTES, ETC) TO SATISFY INSURANCE REQUIRMENTS. THANK YOU.

ATTACHED FORMS

☐ Face Sheet
☐ History & Physical
☐ Labs
☐ Medication List

ACCESS

☐ PICC
☐ Peripheral
☐ No Access

PHYSICIANS ORDERS: Dose: _____ Frequency _____ x _____ Duration

PHYSICIAN SIGNATURE: _____ DATE: _____

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.