

# 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:**

- |   |  |                                     |                                 |
|---|--|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Ceftriaxone (Rocephin) | <input type="checkbox"/> Dalvance              | <input type="checkbox"/> Solumedrol | <input type="checkbox"/> Prolia |
| <input type="checkbox"/> Daptomycin (Cubicin)   | <input type="checkbox"/> Telavancin (VIBATIV)  | <input type="checkbox"/> Reclast    |                                 |
| <input type="checkbox"/> Ertapenem (Invanz)     | <input type="checkbox"/> Tigecycline (Tygacil) | <input type="checkbox"/> IVIG       |                                 |
| <input type="checkbox"/> Vancomycin             | <input type="checkbox"/> Gentamicin            | <input type="checkbox"/> Remicade   |                                 |
| <input type="checkbox"/> Other: _____           |  |                                     |                                 |

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

**ATTACHED FORMS**

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Face Sheet         | <b>ACCESS</b>                       |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> PICC       |
| <input type="checkbox"/> Labs               | <input type="checkbox"/> Peripheral |
| <input type="checkbox"/> Medication List    | <input type="checkbox"/> 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.**

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