Citrus
INFUSION & INJECTION CENTER

Fax # (352) 503-2443

Referral Form

PATIENT INFORMATION:

______________________________ Sex: ☐ Male ☐ Female
Name (First, MI, Last)

______________ ______________ ______________
Date of Birth (MM/DD/YYYY) SSN Email

______________ ______________
Mobile Phone Number Alternative Phone Number (if available)

____
Street Address

______________ ______________ ______________
City State Zip Code

INSURANCE INFORMATION:

☐ **Check if Patient does not have insurance**

☐ **Attach a copy of both sides of patient's MEDICAL insurance**

______________ ______________
Primary Insurance Provider Policy Number

____
Policyholder Name (First, MI, Last) if other than the patient

______________ ______________
Policyholder Date of Birth (MM/DD/YYYY) Insurance Phone Number

______________ ______________
Secondary Insurance Provider Policy Number

____
Policyholder Name (First, MI, Last) if other than the patient

______________ ______________
Policyholder Date of Birth (MM/DD/YYYY) Insurance Phone Number

REFERRING PRESCRIBER INFORMATION:

______________________________ ______________
Referring Prescriber Name (First, MI, Last) NPI#

______________ ______________ ______________
Prescriber's Email Adress (to send confirmation of patient treatment) Direct Phone Number Direct Ext.

______________ ______________

Citrus INFUSION & INJECTION CENTER

Fax # (352) 503-2443

Office Phone Number ____________________ Office Fax Number ____________________

Street Address ____________________

City ____________________ State ____________________ Zip Code ____________________

Your Name ____________________ Your Direct Contact # ____________________ Your Direct Ext.# ____________________

Your Email Address (to send confirmation of patient treatment) ____________________ Your Fax Number (if different from Office Fax Number) ____________________

Patient Name (First, MI, Last) ____________________ Date of Birth (MM/DD/YYYY) __________

ALL FIELDS MARKED WITH * ARE REQUIRED. Incomplete forms will NOT be processed.

***Primary Diagnosis:** ____________________ ***CPT Code:** ____________________

Secondary Diagnosis: ____________________ **CPT Code:** ____________________

***Medication:** ____________________

***Induction Dose:** ____________________ ***Maintenance Dose:** ____________________

***Duration:** ____________________ ***Frequency:** ____________________ ***Refills (x 12 months):** ____________________

PRE-MEDICATIONS TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED: YES___ NO___

- Acetaminophen __ 325mg PO __500mg PO__650mg PO __1000mg PO
- Cetirizine __10mg PO
- Decadron ___20mg PO or via IV: ___8mg IV __20mg IV
- Diphenhydramine __25mg PO __50mg PO **or via IV:** __25mg IV __50mg IV
- Famotidine __20mg PO __40mg PO **or via IV:** __20mg IV __40mg IV
- Fexofenadine __60mg PO __180mg PO
- Methylprednisolone __40mg IV __125mg

ADVERSE REACTION & ANAPHYLAXIS ORDER: ___YES

Will administer acute infusion and anaphylaxis medications per Citrus Infusion & Injection Center's standing adverse reaction orders.

SIGN HERE

Prescriber Signature* ("Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute) **Date* (MM/DD/YYYY)**