Citrus
INFUSION & INJECTION CENTER

Fax # (352) 503-2442

Referral Form

PATIENT INFORMATION:

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

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 <u>MEDICAL</u> insurance and <u>PRESCRIPTION</u> insurance cards.**

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

Pharmacy Insurance Provider Policy Number

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

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

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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. _____

Office/Clinic/Institution Name _____ Specialty _____

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) _____

Medication Order: _____

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	☐	25mg	☐	50mg					
	Methylprednisolone	☐	40mg	☐	125mg	☐	Other:			
	Famotidine	☐	20mg	☐	40 mg					
	Other:	☐								

PO	Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg
	Famotidine	☐	20mg	☐	40mg				
	Diphenhydramine	☐	25mg	☐	50mg				
	Fexofenadine	☐	60mg	☐	180mg				
	Cetirizine	☐	10mg						
	Loratadine	☐	10mg						
	Other:	☐							

Primary Diagnosis: _____ **CPT Code** _____

Secondary Diagnosis _____ **CPT Code** _____

Therapy Dosing:

Frequency:

SIGN HERE

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