

Referral Form for Infusion

PLEASE FAX this completed form and the documents (listed below) to:
(530) 276-0077 (fax)

Referring Physician

Date (mm/dd/yy):

Referring Physician Name / Facility:

Address:

Phone:

Fax:

NPI Number:

Patient Information:

Patient Name:

Patient DOB (mm/dd/yy):

Patient Contact Number:

Patient Insurance (Primary):

Patient Insurance (Secondary):

Patients PCP:

Infusion Details:

Recommended / Ordered Treatment (please include your order):

Pre-Medications Needed:

To ensure timely scheduling, please FAX the following documents:

Copy of patient demographics

Copy of insurance cards

Last 3 visit notes

All pertinent labs/imaging from the last year
(including TB and Hepatitis testing results)

The ORDER for GI Infusion, medication treatment
and dose recommended