



HOME INFUSION GROUP

DERMATOLOGY REFERRAL FORM

FAX: 718-676-9111
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Email: welcome@higny.com

PATIENT INFORMATION

Patient Name:
Home Address:
City, State, Zip:
Home Phone:
Cell Phone:
SS:
Date of Birth:
Gender: Male Female
Contact Person & #:

PRESCRIBER INFORMATION

Prescriber Name:
Home Address:
City, State, Zip:
Phone:
Fax:
DEA:
License:
NPI #:

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription card)

Primary Insurance: ID#: Group:
Secondary Insurance: ID#: Group:
Prescription Card: ID#: BIN: PCN: Group:

DIAGNOSIS/ ICD 10 CODE

Diagnosis checkboxes and lines

PRIOR FAILED MEDICATIONS

Prior failed medications lines

PATIENT EVALUATION

Patient Weight: Kg/ Lbs. Height: Inches/CM Allergies:
Does pt. have any active Infection? No Yes Date of TB Test: negative positive Is the pt. currently on Methotrexate? Yes No

PRESCRIPTION INFORMATION

Table with 5 columns: Medication, Dose and Strength, Directions, Quantity, Refills. Rows include Enbrel, Humira, Remicade, Stelara, and Other.

Other Medications

PREMEDICATE: Diphenhydramine (Benadryl) mg PO Inj. APAP (Tylenol) mg PO Other:
PRN for Anaphylactic Reaction: Hydrocortisone 100mg IV Push Epinephrine 0.3mg IM Sodium Chloride 0.9%: 250 ml 500 ml

Sodium Chloride 0.9% Flush 3 ml 5 ml 10 ml 20 ml 30 ml Flush IV line before and after infusion
Heparin Flush 10 units/ml 3 ml 5 ml Flush IV line after infusion
Heparin Flush 100 units/ml 3 ml 5 ml Flush IV line after infusion

NURSING: Requires Placement PIV Midline IV Line for administration and nurse to administer infusion in home

IV Line: PIV PICC Midline PORT Other: # Number of Lumens Delivery Method: Gravity Infusion Pump
Therapy Start Date: Length of Therapy: Pharmacy to coordinate home health nursing visit as necessary: Yes No

By signing this form and utilizing our services, you are authorizing Home Infusion Group, Inc. and it's employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: (required) Date: (required)

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