



HOME INFUSION GROUP

INFUSION THERAPY REFERRAL FORM

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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 drug card)

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

PATIENT EVALUATION

Patient Weight: Kg/ Lbs. Height: Inches/cm Allergies:
Diabetic: Yes No If Yes, Insulin Dependent:
Date of negative positive TB Test:
Any prior treatment: Yes (provide information below) No

Table with 4 columns: Prior Therapy, Reason for Discontinuation of Therapy, Approximate Start Date, Approximate End Date

DIAGNOSIS

Primary Diagnosis: ICD-10 Code:
Secondary Diagnosis: ICD-10 Code:

CURRENT PATIENT MEDICATIONS

Medication list area with lines for text entry

PRESCRIPTION INFORMATION

Table with 3 columns: Medication, Dose and Route; Rate and Frequency; Duration

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

Current IV Access: 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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