Infusion Referral Form

PATIENT INFORMATION

PATIENT NAME: ______________________ DOB: __________ PHONE: __________

MEDICAL INFORMATION

DIAGNOSIS: ______________________ ICD-10 CODE: __________

PATIENT WEIGHT: __________ PATIENT HEIGHT: __________ ANTICIPATED DISCHARGE DATE: __________

HOME HEALTH AGENCY

VENOUS ACCESS: TYPE: __________ #LUMENS: __________

OTHER ACCESS: TYPE: __________

PHYSICIAN WHO WILL FOLLOW AND/OR WRITE OUTPATIENT ORDERS: ______________________

PLEASE PROVIDE:

- ◯ DEMOGRAPHICS
- ◯ INSURANCE INFORMATION – MEDICAL/PRESCRIPTION CARDS
- ◯ CLINICAL/PROGRESS NOTES
- ◯ MEDICATION ORDERS
- ◯ RECENT LAB RESULTS
- ◯ DISCHARGE LAB ORDERS
- ◯ TEST SUPPORTING PRIMARY DIAGNOSIS

ONCE WE RECEIVE ALL NECESSARY DOCUMENTATION, WE WILL SCHEULE THE PATIENT'S TREATMENT.

CONTACT INFORMATION

DISCHARGE PLANNER/SOCIAL WORKER CONTACT: ______________________

PHONE: __________

FAX: __________

PHARMACY INFORMATION

Maxor Specialty Pharmacy
6101 43rd St Suite C
Lubbock, TX 79407
Phone: 833-789-5324
Fax: 806-791-1918

Maxor Specialty Pharmacy
216 S Polk Street
Amarillo, TX 79101
Phone: 800-657-7122
Fax: 806-355-5288

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