ELECTRA
MEMORIAL HOSPITAL

INFUSION THERAPY REFERRAL FORM

PLEASE FAX TO (940) 298-1640

PATIENT INFORMATION

Referral Date: ______________________________________

Patient Name: _____________________________________ DOB: ______________________________________

Sex (M/F): __________ Age: __________ Weight: __________ Height: __________

Address: _______________________________________ City/State _______________________ Zip _____________

County: _______________________

Phone Number: _______________________________

Primary Insurance: _____________________________ Secondary Insurance: ______________________________

PRIMARY OFFICE CONTACT: ___________________________________

Phone number: ___________________________ Fax: __________________________ Email: ________________________________

MEDICATION FOR INFUSION: ____

Dosage: ____

Frequency: ____

Diagnosis Code: ____

Labs: ____

Other: ____

HEALTHCARE PROVIDER INFORMATION

Ordering physician name: ________________________________ NPI: ___________________________________

SIGNATURE (required): ____

PLEASE SEND INSURANCE INFORMATION, RECENT H&P, LABS AND CURRENT MEDICATIONS