InfuCare Rx

Oncology Referral Form

of Pages Faxed:_____
Fax Referral To: 844-504-3278
Phone: 877-327-8881

Date Required:_____ Ship To: ☐ Patient ☐ MD Office ☐ Other:_____

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Date of Birth:_____ ☐ Male ☐ Female
Emergency Contact:_____ Phone:_____

PRESCRIBER INFORMATION

Prescriber Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
DEA #:_____ NPI #:_____
Contact Person:_____

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:_____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ C80.1 Malignant neoplasm, unspecified
☐ Other:_____
Prior Medication Failed:_____
Length of Treatment:_____
Reason for Discontinuation:_____

Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in %BSA:_____
Allergies:_____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other:_____
For all blood stimulating products please send a copy of most recent labs drawn.

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills

ADDITIONAL COMMENTS

Prescriber Signature:_____ **Date:**_____

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