InfuCare Rx

Nephrology Referral Form

of Pages Faxed: _____
Fax Referral To: 844-533-1131
Phone: 844-773-6779

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

☐ N18 Unspecified Kidney Disease
☐ 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: _____

Lab Results:
Hematocrit: _____ % Date: _____
Hemoglobin: _____ % Date: _____
Platelets: _____ % Date: _____
Serrum Ferrite: _____ ng/mL Date: _____
Transferrin Saturation (TSAT): _____ Date: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills
Aranesp®			☐ 1 month supply	
Epogen®			☐ 1 month supply	
Procrit®			☐ 1 month supply	
Rayaldee®	☐ 30 mcg ☐ 60 mcg	☐ Take 1 capsule by mouth daily	☐ 1 month supply	
Samsca®			☐ 1 month supply	
Sensipar®			☐ 1 month supply	
Zemplar®			☐ 1 month supply	
Other:				

ADDITIONAL COMMENTS

Prescriber Signature: _____ **Date:** _____