Email: intake@infuseone.com | Phone: 1-800-581-0645 | Please refer to website www.infuseone.com for location specific fax numbers



Referral Checklist

REFERRING OFFICE, ALSO FAX

- · Order
- · Most recent labs Supporting clinical notes

NOTE: When sending a referral, the Referral Checklist is not required. The information specified must be included, either on this form or on attached documentation.

Patient Name	DOB	Gender	
Address	Email		
City, State, Zip Code	Home Phone		
Enrolled in Funded Program? Yes No	N/A Mobile Phone		
[] Patient is interested in patient support programs			
[] Patient Insurance			
[] Front and back of insurance card attached (If YE	S, you may skip the Patient	Insurance section.)	
Primary Payer	Group #		
Subscriber Name	ID #		
Secondary Payer	Group #		
Subscriber Name	ID #		
[] Order, Diagnosis, and Clinical Information	1		
[] Order, Diagnosis and Clinical Information attach	ned		
(Go to www.infuseone.com to download a therapy-s	specific order form and revie	w the supporting clinicals.)	
[] Contact Information*			
Contact Information attached (If YES, you may s	skip the Contact Information	section below.)	
Contact Name		·	
Title	Phone		