Fax: 561-516-6626 | Email: Info@infuseone.com | Phone 561-337-4055

INFUSE ONE

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 Demographics

[ ] Patient demographics attached (If YES, you may skip the Patient Demographics section.)

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 YES, you may skip the Patient Insurance section.)

Primary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Secondary Payer _____ Group # _____

Subscriber Name _____ ID # _____

[ ] Order, Diagnosis, and Clinical Information

[ ] Order, Diagnosis and Clinical Information attached

(Go to www.infuseone.com to download a therapy-specific order form and review the supporting clinicals.)

[ ] Contact Information*

[ ] Contact Information attached (If YES, you may skip the Contact Information section below.)

Contact Name _____ Practice Name _____

Title _____ Phone _____ Email _____