



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 _____