Maxor SPECIALTY PHARMACY

Infusion Referral Form

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ PHONE: _____

MEDICAL INFORMATION

DIAGNOSIS: _____ ICD-10 CODE: _____

PATIENT WEIGHT: _____ PATIENT HEIGHT: _____ ANTICIPATED DISCHARGE DATE: _____

HOME HEALTH AGENCY

VENOUS ACCESS: TYPE: _____ #LUMENS: _____

OTHER ACCESS: TYPE: _____

OUTPATIENT FOLLOWING PHYSICIAN: _____

PLEASE PROVIDE:

- ○ DEMOGRAPHICS
- ○ INSURANCE INFORMATION - MEDICAL/PRESCRIPTION CARDS
- ○ CLINICAL/PROGRESS NOTES
- ○ MEDICATION ORDERS
- ○ RECENT LAB RESULTS
- ○ DISCHARGE LAB ORDERS
- ○ TEST SUPPORTING PRIMARY DIAGNOSIS

ONCE WE RECEIVE ALL NECESSARY DOCUMENTATION, WE WILL SCHEDULE THE PATIENT'S TREATMENT.

CONTACT INFORMATION

DISCHARGE PLANNER/SOCIAL WORKER CONTACT: _____

PHONE: _____

FAX: _____

PHARMACY INFORMATION

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