Miscellaneous Referral Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯M ◯F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Emergency Contact: _____ Phone Number: _____

Medical Information

Primary Diagnosis: _____

ICD-10 Code: _____

Allergies: _____

(or provide a list)

Is the patient Diabetic: ◯Y ◯N

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card, 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs.

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Drug Order/Information

Medication: _____

Doses Authorized: _____

Administration Instructions:

_____

_____

Premedication(s)

Common Pre-Medication Orders:

- ☐ Diphenhydamine 25 mg PO
- ☐ Diphenhydramine 50 mg IV
- ☐ Cetirizine 10mg PO
- ☐ Loratadine 10mg PO
- ☐ Acetaminophen 650 mg PO
- ☐ Solumedrol_____ mg IV
- ☐ Normal Saline (0.0%)_____ mg IV
- ☐ Other: _____
- ☐ NONE

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Substitution Allowed ☐

Dispense as Written ☐

Physician's NPI# _____

Prescriber's Signature _____ Date _____