

Miscellaneous Referral Form

Fax Referral To:
877-438-9380



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:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Diphenhydramine 25 mg PO | <input type="checkbox"/> Diphenhydramine 50 mg IV | <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Loratadine 10mg PO |
| <input type="checkbox"/> Acetaminophen 650 mg PO | <input type="checkbox"/> Solumedrol _____ mg IV | <input type="checkbox"/> Normal Saline (0.9%) _____ mg IV | |
| <input type="checkbox"/> Other: _____ | | | |
| <input type="checkbox"/> 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. Prescriber'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 ☐

Physician's NPI# _____

Dispense as Written ☐

Prescriber's Signature _____

Date _____

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRX Services, Inc. All rights reserved.