Miscellaneous Referral Form

CONTINUUMRX
Specialty Infusion Services™
In Partnership with Major Health Systems

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:

- ☐ **Diphenhydamine 25 mg PO**
- ☐ **Diphenhydramine 50 mg IV**
- ☐ **Cetirizine 10mg PO**
- ☐ **Loratadine 10mg PO**
- ☐ **Acetaminophen 650 mg PO**
- ☐ **Solumedrol_____ mg IV**
- ☐ **Normal Saline (0.9%)_____ 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 _____