ClinIVoy INFUSION CARE

844-243-7833 Phone
844-893-7279 Fax
QUESTIONS? Please contact us!
Info@.ClinIVoy.com

Patient Referral Form

Send your referral to: _____

Date Medication Needed: _____

1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birthdate: _____ Sex: (○) Male (○) Female Height: _____ Weight: _____ ( ) lbs. ( ) kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: _____

2. Referring Physician Information

Referral Name: _____ Specialty: _____ NPI Number : _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____ Phone: _____

3. Diagnosis/Clinical Information

Please include recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Body Weight: _____ lb/Kg Age: _____ Adult/Pediatric: _____

Diagnosis:

☐ ICD-10
☐ ICD-10
☐ ICD-10
☐ ICD-10

Lab Work:

☐ ☐ _____
☐ ☐
☐ ☐

History / Current Medical Status:

_____

_____

Tried and Failed Medication:

_____

_____

4. Prescription Information

Drug Name	Strength	Dose / Frequency / Route	Refill

5. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

_____ _____

Patient Signature **Date**

6. Referring Physician Signature

Prescriber, please sign and date below

_____ _____ _____ _____

Referring Signature **Date** **Substitution Permissible** **Date**

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**