REFERRING OFFICE, ALSO FAX: 330-294-2082

- Order
- Most recent labs
- Supporting clinical notes

Referral Checklist

INDY INFUSION

NOTE: When sending a referral, the Referral Checklist is not required. The information specified must be included, either on this form or on attached documentation.

[ ] Patient Demographics

[ ] Patient demographics attached (If YES, you may skip the Patient Demographics section.)

Patient Name _____ DOB _____

Address_____ Email _____

City,State, Zip _____ Home Phone _____

Enrolled in Funded Program?_____ Yes _____ No _____ N/A

Mobile Phone _____

[ ] Patient is interested in patient support programs

[ ] Patient Insurance

[ ] Front and back of insurance card attached (If YES, you may skip the Patient Insurance section.)

Primary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Secondary Payer _____ Group # _____

Subscriber Name _____ ID # _____

[ ] Order, Diagnosis, and Clinical Information

[ ] Order, Diagnosis and Clinical Information attached

[ ] Contact Information*

[ ] Contact Information attached (If YES, you may skip the Contact Information section below.)

Contact Name _____ Practice Name _____

Title _____ Phone _____

Email_____ Fax_____