University Hospitals
UH Meds

Patient Label

PATIENT REFERRAL FORM

Please fax this form with the requested information back to the preferred treatment site. Allow 10 business days to obtain an authorization through the patient's insurance company. Once precertification is complete, clinic staff will be notified and will call your patient to schedule.

Patient Name:_____

Requested Therapy:_____

PROVIDER INFORMATION – PLEASE PRINT

Practice Name:_____

Prescriber Name:_____

Prescriber/Designee Direct Phone Number:_____

DOCUMENTATION NEEDED

- Completed Medication Order Set(pages 2-3)
- Documentation of lab/test results needed related to clinical clearance of requested medication
- Face sheet from current provider's office
- Copy of insurance cards if available
- If out of UH network include:
  - Release of medical information
  - Most recent office visit note

SELECT PREFERRED LOCATION

☐ Warrensville Specialty Care Clinic and Infusion Center
24865 Emery Road, Suite A
Warrensville Heights, Ohio 44128
216-755-5380 | Fax: 216-201-6169

☐ North Ridgeville Specialty Care Clinic and Infusion Center
32800 Lorain Road
North Ridgeville, Ohio 44039
440-406-5510 | Fax: 440-406-5559

☐ Specialty Care Clinic and Infusion Center
UH TriPoint Medical Center
7580 Auburn Road, Suite 207
Concord, Ohio 44077
440-354-1802 | Fax: 440-354-1245

☐ UH Streetsboro Outpatient Infusion Center
9318 State Route 14, Suite 1-A
Streetsboro, OH 44241
330-422-7707 | Fax: 216-201-5612

Thank you for choosing University Hospital's Outpatient Specialty Clinic and Infusion Centers, we look forward to providing exemplary care to your patients!

Sincerely,

The Staff of the UH Outpatient SpecialtyClinics and Infusion Centers

University Hospitals
UH Meds

Patient Label

MEDICATION ORDER SET

All fields must be completed prior to submission. Incomplete orders will be returned to provider.

PATIENT INFORMATION

Name & DOB	
Address	
Phone	
ICD-10 CODE	
Height	
Weight	
Gender	
Allergies	

PRESCRIBER INFORMATION

Printed Name	
Address	
Phone	
Fax	
DEA	
NPI	
State License	

Prescriber Signature: _____ Date:_____

Printed Name: _____

This signed document serves as consent for prior authorization to be obtained by the UH Outpatient Specialty Clinics & Infusion Centers

University Hospitals
UH Meds

Patient Label

MEDICATION INFORMATION

Name of Drug	
Circle One	First Dose OR Continuation: last received on_____ Due On:_____
Dose	
Route	
Frequency	
Pre Treatment Parameters/Labs	
Premedications: PO or IV?	
Number of refills	
Substitutions allowed?	

NOTES/COMMENTS:

Prescriber Signature: _____ Date:_____

Printed Name: _____

This signed document serves as consent for prior authorization to be obtained by the UH Outpatient Specialty Clinics & Infusion Centers