Referral for Injectable Medication

University Hospitals Home Care Services

4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

_____

Patient Information

Name: _____ **DOB:** _____ ☐**M** ☐**F**

Address: _____

Phone: _____ **2nd Phone:** _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (Include ICD-10 Code): _____

Weight:_____ ☐lb ☐kg **Height:**_____ ☐in

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

Significant medical history:_____

Will this be the patient's first dose? ☐Yes ☐No (If no, date of last dose: _____) **Response to prior doses**: _____

Additional notes: _____

_____

_____

Prescription Information

Medication: _____ **Dose:** _____ **Route of administration:** _____

Frequency:_____ **Quantity (# of doses):** _____

Instructions: Home Care to provide supply items and nursing care to prepare and administer product as per package instructions.

Additional instructions:_____

Lab orders: List any outpatient laboratory work related to this therapy you would like Home Care to draw in conjunction with the patient's medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated. (Lab orders are subject to availability)

_____

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____