

Referral for Injectable Medication



University Hospitals Warrensville Heights, OH 44128
Home Care Services

4510 Richmond Road

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: _____ <input type="checkbox"/> M <input type="checkbox"/> F Address: _____ Phone: _____ 2 nd Phone: _____ MRN: _____ Primary Language: _____ Functional Limitations: _____
Clinical Information	Diagnosis (Include ICD-10 Code): _____ Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior treatments & reason for discontinuation: _____ _____ Significant medical history: _____ Will this be the patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

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