AMERICAN RIVER INFUSION SERVICES	INFUSION THERAPY REFERRAL FORM	FAX: Phone: (916)239-7900 Email: intake@arinfusion.com

PATIENT INFORMATION

Patient Name:_____
Home Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
SS #: _____
Date of Birth:_____Gender: ☐ Male ☐ Female
Contact Person & #: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Home Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____License #: _____
NPI #: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)

Primary Insurance:_____ID#:_____Group:_____
Secondary Insurance:_____ID#:_____Group:_____
Prescription Card:_____ID#:_____BIN:_____PCN:_____Group: _____

PATIENT EVALUATION

Patient Weight:_____Kg/ Lbs. Height:_____Inches/cm Allergies: _____ _____
Diabetic: ☐ Yes ☐ No If Yes, Insulin Dependent: ☐ **Date** of ☐ negative ☐ positive **TB Test**:_____
Any prior treatment: ☐ Yes (provide information below) ☐ No

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

DIAGNOSIS

Primary Diagnosis: _____
ICD-10 Code: _____
Secondary Diagnosis: _____
ICD-10 Code: _____

CURRENT PATIENT MEDICATIONS

_____ _____ _____
_____ _____ _____

PRESCRIPTION INFORMATION

Medication, Dose and Route	Rate and Frequency	Duration

Other Medications

PREMEDICATE: ☐ **Diphenhydramine (Benadryl)**_____mg ☐ PO ☐ Inj. ☐ **APAP (Tylenol)**_____mg PO ☐ Other: _____
PRN for Anaphylactic Reaction: ☐ Hydrocortisone **100mg** IV Push ☐ Epinephrine **0.3mg IM** **Sodium Chloride 0.9%:** ☐ 250 ml ☐ 500 ml

☐ Sodium Chloride 0.9% **Flush** ☐3 ml ☐5 ml ☐10 ml ☐20 ml ☐30 ml ☐ Flush IV line before and after infusion
☐ Heparin Flush **10** units/ml ☐3 ml ☐5 ml ☐ Flush IV line after infusion ☐ **Labs**_____
☐ Heparin Flush **100** units/ml ☐3 ml ☐5 ml ☐ Flush IV line after infusion

NURSING: Requires Placement ☐ PIV ☐ Midline IV Line for administration and nurse to administer infusion in home

Current IV Access: ☐PIV ☐PICC ☐Midline ☐PORT ☐OTHER_____**# Number of Lumens** Delivery Method: ☐Gravity ☐Infusion Pump
Therapy Start Date:_____Length of Therapy:_____Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

By signing this form and utilizing our services, you are authorizing Home Infusion Group, Inc. and it's employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature:_____ **Date:** _____
(required) (required)