NEW PATIENT REFERRAL FORM

Referral Date:__________________ Patient Name:____

Date to begin therapy:_________________ D.O.B:_______________Email:_________________________

Work Telephone:_____________________ Cellular:___________________Home: ___________________

Referring Physician:________________________ Telephone:____________________________

Office contact name:________________________ Fax:________________________________

Where does ordering physician have hospital privileges:____

Primary Care Physician:_______________________ Telephone:____________________________

Diagnosis and IDC Codes

473.8	Pansinusitis_________	473.1	Frontal _________
383.9	Mastoiditis _________	473.3	Sphenoid _________
473.2	Ethmoid _________	473	Maxillary _________

Important: please FAX all additional information supporting the above diagnosis

IV Antibiotic Prescription:____

Duration of therapy:_______________________________

Administration route: PICC_______ Midline______ Port_____

Would you like Home Care Solutions to coordinate PICC/Port placement? ________ No ________ Yes

Will the patient receive first IV-ABX dose in your office administered by your staff? ______ No ________ Yes

Patient primary insurance:_______________________________ Policy Number:_________________

(copy of insurance card - both sides) Phone number:_________________________________

Patient secondary insurance:_________________________________ Policy Number:_________________

(copy of insurance card - both sides) Phone number:__________________________________

Please include:

_______ Patient Demographics ________ H & P ________ Medication List

_______ Culture / Sensitivity Results _________Office Notes/ Surgery Reports ________CT Scan

Home Care Solutions Pharmacy Voice 888.273.9820 Fax: 877.644.3895

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