indigo INFUSIONS

REFERRAL FORM

FAX: (210) 767-9795 TEL: (210) 957-1354

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies:	City, State, Zip:
Weight:_____lbs	Patient's Email:

Primary Contact Method: Call Text Email Consent to receive email, text messages from Indigo Infusions? Y N

REQUIRED DOCUMENTATION

o Copy Insurance Card o History & Physical o Patient Demographics o Most Recent Labs o Medication List

PRIMARY DIAGNOSIS

ICD-10 Code: _____

SECONDARY DIAGNOSIS

ICD-10 Code(s): _____

PRE-MEDICATION

List Medication, Dose, Route:

PRIMARY ORDER

Medication: _____

Dose: _____

Route: _____

Frequency: _____

Refills: _____

LINE/ACCESS

☐ Flush device per Indigo Infusions Centers' protocol

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☐ Administer acute infusion reaction and anaphylaxis medications per Indigo Infusions Centers' protocol

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION

Office Contact:	Provider Name:
Address:	Phone:
City, State, Zip:	Fax:
NPI:	Email:

Provider Signature

Date