

Home Infusion Therapy Fax Referral

Please complete and attach signed orders, current labs, history and physical, then fax to Coram at the above number. Coram will call to confirm acceptance on service.

Referral Contact Name			
Phone		Fax	
<input type="checkbox"/> Hospital	<input type="checkbox"/> MD	<input type="checkbox"/> RN Agency	<input type="checkbox"/> Self
<input type="checkbox"/> Other	<input type="checkbox"/> Insurance	<input type="checkbox"/> Case Manager	
Patient Name			DOB
SSN		Parent/Guardian Details	
Address		City, State Zip	
Home Phone		Cell Phone	

Insurance: Provide the following information, or attach photocopy of card, if available.

	Primary		Secondary	
Subscriber Name				
Company				
Group Number				
ID Number				
Patient Relationship to Subscriber	<input type="checkbox"/> Parent <input type="checkbox"/> Child	<input type="checkbox"/> Significant Other <input type="checkbox"/> Other	<input type="checkbox"/> Parent <input type="checkbox"/> Child	<input type="checkbox"/> Significant Other <input type="checkbox"/> Other
Phone				

Primary Diagnosis			Height
Secondary Diagnosis			Weight
Allergies			
Access	<input type="checkbox"/> None	<input type="checkbox"/> Type	

	Therapy 1	Therapy 2
Therapy Ordered	<input type="checkbox"/> Anti-Infective	<input type="checkbox"/> Anti-Infective
	<input type="checkbox"/> Aralast	<input type="checkbox"/> Aralast
	<input type="checkbox"/> Inotrope	<input type="checkbox"/> Inotrope
	<input type="checkbox"/> IVIG	<input type="checkbox"/> IVIG
	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Pain Management
	<input type="checkbox"/> Parenteral Nutrition–Home Start <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Parenteral Nutrition–Home Start <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Other	<input type="checkbox"/> Other
Start of Care Date		
Length of Therapy		

Nursing Agency	<input type="checkbox"/> Referring <input type="checkbox"/> Assigned <input type="checkbox"/> To Be Assigned <input type="checkbox"/> N/A
Prescribing Physician	
Office Contact Person	
Phone	Fax

CONFIDENTIALITY NOTICE: If faxed materials include Protected Health Information (PHI), these records are CONFIDENTIAL. Coram shall receive Authorization from the patient prior to releasing or utilizing PHI for reasons other than treatment, payment or healthcare operations. This information is intended solely for the use of the individual named above. If you are not the intended recipient, you are hereby advised that any dissemination, distribution or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy the original fax message.
 FC001–10/10/08 REV