

V.E.W. Health Infusion Referral Form

Email: frontdesk@vewhealthcare.com

Fax: 702-867-0084

Ph: 702-725-1261

To ensure swift processing of your order, please complete all fields. **V.E.W. Health will complete prior authorizations.**

PATIENT INFORMATION

V.E.W. Health

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Pt. Sex: _____ Pt. Weight: _____ kg Pt. Height: _____ in Pt. Email (opt): _____

Pt. Status: New Patient Continuing Therapy Last Infusion Date (if applicable): _____

DIAGNOSIS DETAILS

Diagnosis: _____ ICD-10 code: _____

Allergies: _____

ORDER DETAILS

Drug Name: _____

Dosing: _____

Frequency: _____

Pre-medications:

- Acetaminophen 650mg PO
- Diphenhydramine 25mg PO or IV
- Hydrocortisone 100mg IV

Methylprednisolone 125mg IV

Other Pre-medications: _____

Infusion Reaction Protocol:

- A-P Medical Reaction Protocol
- Other Reaction Protocol (Please send protocol with order)

ANCILLARY ORDERS (opt.)

Lab Orders: _____ Lab Frequency: _____

Additional Orders: _____

PROVIDER INFORMATION

Practice Name: _____ Provider Name: _____

Signature: _____ Date: _____ Time: _____

Contact Person: _____ Contact Ph: _____ Email: _____

NPI #: _____ Office Ph: _____ Office Fax: _____

PREFERRED LOCATION

City: _____ State: _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

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Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR EXPEDITED ORDER PROCESSING & INSURANCE APPROVAL

- Include completed order, signed by provider (page 1)
- Include patient demographic and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) support primary diagnosis
- Other medical necessity: _____

V.E.W. Health *will provide all necessary documents to the patient's insurance company to confirm eligibility. Our patient-obsessed will inform you if further details are needed. Additionally, we'll discuss financial obligations with the patient and direct them to co-pay assistance options as required.*

Please submit BOTH pages & ALL supporting documentation.

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