



**SEND REFERRAL TO:
CCMC Outpatient Infusion**

 Fax: 254-879-4604

 254-879-4900

Questions? Call us!

Chelsea Moreno, RN — Ext. 4322

Mary Beth Underwood, RN — Ext. 4326

REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient Last Name

Patient First Name

Date of Birth (MM/DD/YYYY)

Gender

Phone Number

Alternate Phone

Address

City, State, ZIP

INSURANCE INFORMATION

Primary Insurance

Member ID / Policy #

Group Number

Insurance Phone

Secondary Insurance (if applicable)

Member ID / Policy #

Insurance Card Copies Attached Medicare Medicaid Self-Pay Other

REFERRING PROVIDER INFORMATION

Referring Provider Name

NPI Number

Practice / Clinic Name

Phone Number

Fax Number

Date of Referral

CLINICAL INFORMATION

Primary Diagnosis / ICD-10 Code(s): _____

Requested Medication / Infusion Therapy:

Urgency

Routine Urgent **STAT**

Relevant Medical History / Clinical Notes

Additional Notes / Clinical Summary

CURRENT MEDICATIONS

Please list all current medications (or attach current medication list):

DOCUMENTS TO INCLUDE WITH REFERRAL

⚠ REQUIRED:

Please attach copies of the following with every referral: (1) Insurance card(s) if available, (2) Clinical notes related to the medication being ordered, and (3) A signed order/prescription for the requested medication from the referring provider.

Please check all that apply:

- Insurance Card(s) Clinical / Chart Notes (related to ordered med) Medical History
 Signed Medication Order from Referring Provider Current Medication List
 Lab Results Prior Authorization Other: _____

Advanced Treatments. Local Care.

CCMC Health System — Outpatient Infusion Department

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