CCMC Health System
INFUSION DEPARTMENT

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.

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