Methylprednisolone Referral Form

Phone 405.548.4848 **Toll Free** 888.848.4588 **Fax** 405.418.4442

PATIENT INFORMATION

Patient Name: ____________________ Date of Referral: ____________________

Address: ____________________ SSN: ____________________ Gender: __________

City, State, Zip: ____________________ DOB: ____________________ Age: __________

Caregiver Name (if other): ____________________ Relationship: __________ Phone: __________

Emergency Contact: ____________________ Relationship: __________ Phone: __________

Primary Insurance Subscriber: ____________________ Primary Language: ____________________

Policy #: __________ Group #: __________ Phone #: ____________________

Insurance Phone: ____________________ Work Phone #: ____________________

MEDICAL HISTORY

Allergies: ☐ NKDA

☐ Yes, listed:____________________

____

Ht:__________ ☐ in ☐ cm

Wt:__________ ☐ lbs ☐ kg

Date Taken:____________________

Please attach and fax
1. Insurance card(s) and demographic information
2. Recent clinical assessment note or H&P
3. Current medication list

PRESCRIPTIONS & ORDERS

IV Access:

☐ Peripheral

☐ Other:____________________

☐ _______ mg/day x _______ day(s) every _______ week(s)

☐ _______ gm/day x _______ day(s) every _______ week(s)

☐ Other:____________________

☐ Special instructions:____________________

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PRIMARY DIAGNOSIS

Diagnosis (Please indicate ICD10-CM code & description):

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Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.	Signature:____________________ Date:____________________

PHYSICIAN INFORMATION

Name: ____________________ Hospital/Clinic: ____________________

Address: ____________________ Office Contact: ____________________

City, State, Zip: ____________________ Phone: __________ Fax: __________

NPI: __________ UPIN: __________ License #: ____________________

CONFIDENTAL HEALTH INFORMATION: Health care information is personal information related to a person's health care. It is being faxed to you after appropriate authoriaztion or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidental manner. Rediscolsure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained.