Referral Form Instructions

Thank you for referring your patient to Saint Agnes Outpatient Infusion. To ensure your order is processed in a timely manner, please fill out the referral form **COMPLETELY.**

*Below is a list of our **standard infusion treatments**. Please call us if you wish to request an alternative treatment.*

Standard infusion treatments: Actemra, Aphereisis, Avsola, Benlysta, Entyvio, Fasenra, Feraheme, Ferrlecit, Ilumya, Iron Dextran, IVIG, IV Antibiotics, IV Hydration, Krystexxa, Lemtrada, Nucala, Ocrevus, Prolia, Remicade, Rhogam, Rituximab, Solu-Medrol, Soliris, Stelara, Therapeutic Phlebotomy, Transfusions, Tysabri, Xolair, Zarxio, and Zoledronic Acid (Reclast)

TREATMENT

- Indicate requested infusion treatment along with the following:
  - Dose (i.e., 250mg)
  - Frequency (2x day)
  - Duration (i.e., 5 days) *If duration is not provided, it will be considered a one-time dose and a new order will be required for subsequent doses.*
  - Route (i.e., IV/injection)
  - Infusion Run Time (i.e., infuse over 2 hours)
- Antibiotic orders must have a **start** and **stop** date

PRE-MEDICATIONS

- If patient requires pre-medications, please indicate the medication, dose, route, frequency and directions.

REQUIRED DOCUMENTATION

For a referral to be considered complete, you **<u>must</u>** attach:

- Patient's demographic and insurance information
- Recent visit notes to support diagnosis (list current height and weight for any weight-based medications)
- Current medications and allergy list
- List of medications previously tried and failed

  Additional requirements for osteoporosis and iron patients
  - Labs listing calcium, BUN, and creatine within one year (osteoporosis patients)
  - Bone density scan report listing T-score within 2 years (osteoporosis patients)
  - Labs listing hemoglobin, ferritin, and iron TSAT within 6 months (for iron patients)

INSURANCE

Please obtain authorization for United Healthcare or any IPA or government plan (Tricare, CHAMPVA, etc.) and Saint Agnes will obtain authorization for all other insurance coverages. We will advise your office if there are any issues with obtaining approval.

Outpatient Infusion
1303 E. Herndon Ave.
Fresno, CA 93720
REFERRALS: 559-450-3522
SCHEDULING: 559-450-3523
FAX: 559-450-2322/559-450-2323

Saint Agnes Medical Center
A Member of Trinity Health

Patient Referral Form

PATIENT INFORMATION Date: ____________________________

Name____

Phone _________________________________ DOB____________________ SSN___________________________

Allergy List: ____

____

REFERRING INFORMATION

PHYSICIAN____________________________________ OFFICE CONTACT________________________________

PHONE___________________________________ FAX____

TREATMENT

Requested Infusion Treatment ____

Dose ___________________ Frequency__________________________ Route (circle one): IV or Injection

Duration* _________________________ **If duration is not specified, it will be considered a one-time dose and a NEW order will be required for subsequent doses.*

Infusion Run Time ___________________

Diagnosis ____ (ICD-10) ___________________________

FOR **ANTIBIOTIC ORDERS** ONLY**:** Treatment **start** date ______________ Treatment **stop** date _______________

REQUESTED PRE-MEDICATIONS (Include Dose, Route, Frequency, Directions)

____

____

____

Physician signature ____ Date ___________________

For faster processing, please include patient's **demographic and insurance information**, along with any relevant **visit notes**, **labs, scans**, etc.

Saint Agnes will verify and obtain prior authorization for treatment. This can take up to 1 week or longer. Once completed, **Saint Agnes will contact your patient to schedule treatment**.

Visit ***www.samc.com/referral-forms*** to download additional referral forms.