SOLEO HEALTH®
Simplifying Complex Care

Acute Home Infusion Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:
p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

PATIENT INFORMATION

Patient Name		DOB	Contact Phone
Address	City	State	Zip
Gender ☐ M ☐ F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐ Allergies		
ICD-10 code (required)		ICD-10 description	
Patient Status ☐ New to Therapy ☐ Continuing Therapy		Discarge Date	SOC Date

PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐ Insurance Cards	☐ History & Physical	☐ Most Recent Labs	☐ Medication List

TREATMENT PLAN

Medication: _____ Dose: _____ Duration: _____

Medication: _____ Dose: _____ Duration: _____

Medication: _____ Dose: _____ Duration: _____

Medication: _____ Dose: _____ Duration: _____

☐ Other	Include dosage, frequency and any other special instructions below
☐ Refills	

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

PREMEDICATION

☐ Include premedication per Soleo's infusion protocol.

☐ Other: _____

LABORATORY ORDERS

☐ CBC every _____

☐ CMP every _____

☐ Other

I authorize the above patient treatment and Soleo Health to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Soleo Health at phone 844.575.1515, fax 844.797.5050, or email specialtyreferrals@soleohealth.com.

_____ Prescriber Name (Print)

_____ Prescriber Signature

_____ Date