

General 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: specialtysreferrals@soleohealth.com

PATIENT INFORMATION					
Patient Name			DOB	Contact Phone	
Address		City	State	Zip	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits		Weight (lb.)	Height (in.)	
<input type="checkbox"/> NKDA		<input type="checkbox"/> Allergies			
ICD-10 code (required)			ICD-10 description		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy		Discharge Date		SOC Date	
PRESCRIBER INFORMATION					
Ordering Prescriber			Prescriber NPI		
Practice Name			Phone	Fax	
Practice Address		City	State	Zip	
REQUIRED DOCUMENTATION					
<input type="checkbox"/> Insurance Cards		<input type="checkbox"/> History & Physical		<input type="checkbox"/> Most Recent Labs	
				<input type="checkbox"/> Medication List	
TREATMENT PLAN					
Medication: _____ Dose: _____ Duration: _____					
Medication: _____ Dose: _____ Duration: _____					
Medication: _____ Dose: _____ Duration: _____					
Medication: _____ Dose: _____ Duration: _____					
<input type="checkbox"/> Other		Include dosage, frequency and any other special instructions below			
<input type="checkbox"/> 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			LABORATORY ORDERS		
<input type="checkbox"/> Include premedication per Soleo's infusion protocol.			<input type="checkbox"/> CBC every _____		
<input type="checkbox"/> Other: _____			<input type="checkbox"/> CMP every _____		
			<input type="checkbox"/> 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 specialtysreferrals@soleohealth.com.

 Prescriber Name (Print) _____ Prescriber Signature _____ Date