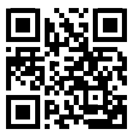
CureStat Rx
Home Infusion and Specialty Pharmacy

INFUSION THERAPY
REFERRAL FORM

6725 MESA RIDGE RD. STE 230. SAN DIEGO, CA 92121
PHONE: (888) 963-6544 FAX: (858) 281-0045



PATIENT INFORMATION

PATIENT NAME:		PRIMARY PHONE:	
DOB:		ADDRESS:	
SSN:		CITY, STATE, ZIP:	
CAREGIVER NAME:		ALTERNATE PHONE:	

INSURANCE INFORMATION
(PLEASE FAX A COPY OF PATIENTS INSURANCE CARD INCLUDING BOTH SIDES)

PRIMARY INS:		SECONDARY INS:	
PLAN ID:		PLAN ID:	

PRIMARY DIAGNOSIS:
(PLEASE PROVIDE ICD-10 CODE)

OTHER:		OTHER:	

CLINICAL INFORMATION

GENDER:	M	F		DIAGNOSIS DATE:	
WEIGHT:	lbs	kg		COMORBIDITIES:	
HEIGHT:	In	cm		CONCOMITANT MEDICATIONS:	
TB/PPD TEST:	Yes	No		ALLERGIES: NKDA OTHER	

IS THIS THE FIRST DOSE? No Yes IF NO, DATE OF LAST INFUSION: NEXT DOSE DUE:

PRIOR THERAPY
(PLEASE PROVIDE MEDICATION HISTORY)

PRIOR THERAPY	YES	NO	REASON FOR DISCONTINUATION OF THERAPY	START DATE	END DATE

REQUIRED DOCUMENTATION:

INSURANCE CARD FRONT AND BACK MOST RECENT LABS H & P

DRUG	DOSE / STRENGTH	DIRECTIONS	QTY	REFILLS

Premedication take 30mins prior to infusion (Note: If nothing is checked, no premeds will be given)

DIPHENHYDRAMINE:	mg PO	**OR**	50mg IV diluted in D5W or NS 50-100mL
ANTIHISTAMINE:	Fexofenadine 180mg	**OR**	Cetirizine 10mg PO
METHYLPREDNISOLONE:	125mg slow IV push over 5 mins	**OR**	mg slow IV push
ACETAMINOPHEN:	mg PO	**OR**	OTHER:

CURRENT IV ACCESS: PIV PICC Midline Port OTHER: Number of lumens:

DELIVERY METHOD: Gravity Infusion Pump

SHIP TO: PATIENT PRESCRIBER'S OFFICE NEEDS BY:

INJECTION TRAINING PROVIDED BY: PRESCRIBER'S OFFICE PHARMACY NA

PRODUCT SUBSTITUION PERMITED:

DISPENSE AS WRITTEN:

PRESCRIBER INFORMATION

PHYSICIAN NAME:		PHONE:		LICENSE #:	
OFFICE CONTACT:		FAX:		NPI #:	
ADDRESS:		CITY, STATE, ZIP:		DEA #:	

PRESCRIBER'S SIGNATURE:		**DATE:**	

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