ATTUNE HEALTH

Autoimmune and Inflammation Care and Research

# INFUSION REFERRAL FORM

**REFFERING MD:**_____ **PHONE**_____ **FAX**_____

**PATIENT NAME:**_____ **DOB:** _____**PATIENT'S WEIGHT**_____

**PATIENT'S ADDRESS** _____

**PATIENT'S TELEPHONE**_____ **ALT PHONE** _____

**PRIMARY / SECONDARY INSURANCE:** _____

**POLICY NUMBER:** _____**EFF DATE:** _____**INSURED'S NAME:**_____
(PRIMARY)

**POLICY NUMBER:** _____**EFF DATE:** _____**INSURED'S NAME:**_____
(SECONDARY)

**When referring a patient to this office, please include the following (used for Utilization Review and/or insurance verification purposes only):**

- **Insurance card copy (front and back)**
- **A copy of your internal demographic sheet**
- **Physician's Order and Pre-meds**
- **Most recent H&P, medical notes and infusion notes**
- **Relevant lab/diagnostic results (please include autoimmune panel)**
- **Latest TB Result**
- **Recent medication list**

**Please fax all referring information to the following: (310) 855-9309**

Once this office is in receipt of your request, we will begin the insurance verification process and attempt to get your patient on the infusion schedule within 5-7 days of the request

Please be advised that our normal process for referrals, for infusions and injections, is to alternate between both physicians in the practice. Please check "No Preference" if you agree with our process:

☐ **No Preference**

Consultation requested from one of our physicians: ☐ **Yes** ☐ **No**

In certain cases, we understand that you may have a preference. If so, please select the physician you like to refer to: ☐ **Dr. Venuturupalli** ☐ **Dr. Wallace** ☐ **No Preference**