FAX all referring information to: (310) 652-6056
Tel: 424-239-6174 Infusioncenter@attunehealth.com
8750 Wilshire Blvd., Suite 350, Beverly Hills, CA 90211

ATTUNE HEALTH
Autoimmune and Inflammation Care and Research

INFUSION & INJECTION REFERRAL FORM

Patient Demographics

PATIENT NAME:_____DOB:_____**PT WEIGHT**: _____

PATIENT ADDRESS:_____

PHONE NUMBER:_____ ALT PHONE NUMBER:_____

EMAIL ADDRESS:_____

Referring Provider Information

REFFERED BY:_____MD PHONE:_____EXT._____FAX:_____

Documentation Checklist

When referring a patient, please include the following documents:

- ☐ **Copy of Insurance card (front and back)**
- ☐ **Patient Demographic Sheet**
- ☐ **Physician's Order and Pre-meds,**
- ☐ **Most recent H&P, medical notes, and infusion notes**
- ☐ **Relevant lab (please include autoimmune panel)**
- ☐ **Diagnostic results**
- ☐ **Latest TB Result**
- ☐ **Recent medication list**
- ☐ **Patient Weight**

Choose a Provider

Please indicate which physician you would like to consult and oversee your patient. Please note all infusion requests will receive a consultation at the time of their first infusion.

☐ Dr. Venuturupalli ☐ Dr. Scaramangas ☐ Dr. Myers ☐ No Preference

Once all information is received, we will attempt to get your patient on our infusion schedule within 5-7 days.

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Provider's Infusion RX Order

PATIENT NAME:_____**DOB**:_____ **WEIGHT**:_____

DRUG

☐Actemra ☐Benlysta ☐Cinqair ☐Entyvio ☐Evenity ☐Fasenra ☐Inflectra ☐Injectafer ☐Leqvio ☐Krystexxa ☐Nucala ☐Ocrevus ☐Orencia ☐Onpattro ☐Prolia ☐Reclast ☐Remicade ☐Rituxan ☐Saphnelo ☐Simponi Aria ☐Soliris ☐Stelara ☐Tepezza ☐Tezspire ☐Xolair ☐Other:_____

ADMINISTER: IV / SQ INJECTION **Dose:_____mg**

FREQUENCY: _____

DURATION:_____

PRE MEDS:_____

DX Code:_____

REFFERED BY_____**MD** ☐ DO NOT SUBSTITUTE