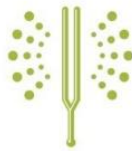


FAX all referring information to: (310) 652-6056

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

REFERRED BY: _____ MD PHONE: _____ EXT. _____ FAX: _____

Documentation Checklist

When referring a patient, please include the following documents:

- | | |
|---|---|
| <input type="checkbox"/> Copy of Insurance card (front and back) | <input type="checkbox"/> Relevant lab (please include autoimmune panel) |
| <input type="checkbox"/> Patient Demographic Sheet | <input type="checkbox"/> Diagnostic results |
| <input type="checkbox"/> Physician's Order and Pre-meds, | <input type="checkbox"/> Latest TB Result |
| <input type="checkbox"/> Most recent H&P, medical notes, and infusion notes | <input type="checkbox"/> Recent medication list |
| | <input type="checkbox"/> 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.

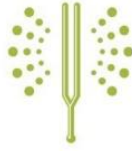
- Dr. Venuturupalli Dr. Scaramangas Dr. Myers No Preference

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

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

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: _____

REFERRED BY _____ **MD**

DO NOT SUBSTITUTE