# Home I.V. Care

Physician Referral Form

32751 Edward Street, Suite 101
Madison Heights, MI 48071
Toll-free: 1-800-544-7085
Fax: (248) 577-5660

Thank you for referring your patient to Home I.V. Care. Please complete this form and fax to (248) 577-5660 or email to sworthy@homeiv.net. Our clinical team will follow up promptly. For urgent starts, call 1-800-544-7085.

## 1. Patient Information

Patient Name (Last, First, MI)

Date of Birth

Street Address

City, State, ZIP

Home Phone

Mobile Phone

Emergency Contact / Relationship

Emergency Contact Phone

Primary Insurance

Member / Policy ID

Secondary Insurance (if any)

Group #

## 2. Referring Provider

Physician Name

NPI / License #

Practice / Facility

Specialty

Office Phone

Office Fax

Preferred Contact for Clinical Updates

## 3. Required Documentation (check all that apply)

- ☐ Insurance Cards
- ☐ History & Physical
- ☐ Most Recent Labs
- ☐ Medication List

## 4. Therapy Requested (check all that apply)

- ☐ Antibiotic / Antimicrobial IV
- ☐ TPN / Parenteral Nutrition
- ☐ IVIG / Immunoglobulin
- ☐ Hydration Therapy
- ☐ Pain Management
- ☐ Other Specialty Infusion

If Other, please specify

Requested Start Date / Urgency

## 5. Prescription / Clinical Details

Diagnosis / ICD-10

Medication(s), Dose, Frequency, Duration

Allergies

Vascular Access (e.g., PICC, Midline, Port) / Placement Date

Additional clinical notes / comments

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## 6. Authorization & Signature

I authorize Home I.V. Care to provide the ordered home infusion services and to contact the patient regarding therapy coordination, benefits verification, and delivery of medications and supplies.

Physician Signature _____ Date _____

Print Name / Credentials _____

**Submit: Fax (248) 577-5660 | Email sworthy@homeiv.net | Questions? 1-800-544-7085**