



NEW PATIENT REFERRAL FORM

Referral Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Date to begin therapy: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Email: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Cellular: \_\_\_\_\_ Home: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Office contact name: \_\_\_\_\_ Fax: \_\_\_\_\_

Where does ordering physician have hospital privileges: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Diagnosis and IDC Codes

473.8 Pansinusitis \_\_\_\_\_ 473.1 Frontal \_\_\_\_\_

383.9 Mastoiditis \_\_\_\_\_ 473.3 Sphenoid \_\_\_\_\_

473.2 Ethmoid \_\_\_\_\_ 473 Maxillary \_\_\_\_\_

Important: please FAX all additional information supporting the above diagnosis

IV Antibiotic Prescription: \_\_\_\_\_

Duration of therapy: \_\_\_\_\_

Administration route: PICC \_\_\_\_\_ Midline \_\_\_\_\_ Port \_\_\_\_\_

Would you like Home Care Solutions to coordinate PICC/Port placement? No Yes

Will the patient receive first IV-ABX dose in your office administered by your staff? No Yes

Patient primary insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

(copy of insurance card - both sides) Phone number: \_\_\_\_\_

Patient secondary insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

(copy of insurance card - both sides) Phone number: \_\_\_\_\_

Please include:

\_\_\_\_\_ Patient Demographics \_\_\_\_\_ H & P \_\_\_\_\_ Medication List

\_\_\_\_\_ Culture / Sensitivity Results \_\_\_\_\_ Office Notes/ Surgery Reports \_\_\_\_\_ CT Scan

Home Care Solutions Pharmacy Voice 888.273.9820 Fax: 877.644.3895

630 N Wymore Road Suite 370 Maitland FL 32751 www.SinuCare.com