GENERAL REFERRAL FORM

FLOURISH™
HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ■ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

PRIMARY DIAGNOSIS

■ ICD-10 Code:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

Please include MEDICATION, DOSE, ROUTE, FREQUENCY, DURATION, and any additional administration instructions:

_____

_____

_____

_____

_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Infusion Centers' protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol
(See flourishhealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date