# Center for Infusion

**Phone: 716-898-5376**
**Fax: 716-898-3509**

Today's Date: **Referral Status:** ○ New Referral ○ Updated Order ◉ Order Renewal

**PATIENT INFORMATION:**

Patient Name: _____ DOB: _____

Allergies: _____

Weight (kg): _____

ICD-10 Code(s) & Description (required): _____

☐ (required): The patient's demographics, insurance, lab results, meds, consent form and recent office visit notes were sent to ECMC Center for Infusion.

The patient has an existing prior authorization:

○ Yes (fax to 716-898-3509), PA#: _____ ○ Not Required (Please provide reference #)

Auth Dates/# of approved visits: _____ _____

**PHARMACY BENEFITS INFORMATION:**

Insurance Carrier: _____ Group #: _____ ID#: _____

**PATIENT INSURANCE:**

Primary: _____ Group #: _____

Subscriber Name: _____ ID#: _____

Secondary: _____ Group #: _____

Subscriber Name: _____ ID#: _____

**PRESCRIBING OFFICE INFORMATION:**

Referral Contact Name and Phone Number: _____

Ordering Provider: _____ Provider NPI: _____

Practice Name: _____ Phone: _____ Fax: _____

**ORDERS AND CLINICAL DOCUMENTATION:**

Medication: _____ Dose: _____

Frequency: _____ # of treatments required: _____

Date of last infusion (if not with ECMC): _____

**Additional Notes from Referring Office:**

Provider Name (Print) _____Provider Signature_____