Mon Health
Preston Memorial Hospital

Patient Information Label or:

Name: _____

DOB: _____

Infusion Center Referral/Order

Admit to: Outpatient Infusion Center

Date:_____

Diagnosis: _____

For Medications, the following must be provided:

- Drug: _____
- Dose: _____
- Route: _____
- Frequency: _____
- Duration: _____

☐ This is a culture proven treatment and culture results provided.

Antiemetics/Emergency Medications:

_____

_____

Provider Name: _____

Provider Signature: _____

Phone: _____ Fax:_____

Authorization

Authorization obtained for PMH pharmacy to provide the medication? ☐ Yes ☐ No

Preston Memorial Hospital's tax ID number: 31-1097818 NPI: 1013950054

If no, what pharmacy will be sending the drug? _____

Authorization Number: _____

Valid dates and visits approved: _____

If no authorization required, is pre-determination of covered benefits needed? ☐ Yes ☐ No

Please list reference number and name of the person with whom you've spoken to:

_____

☐ Progress notes attached ☐ Insurance/Demographic information attached

Please fax to the Infusion Center at: (304) 329-7281

After we receive the completed order (including progress notes, authorization, and insurance/demographic information), our infusion center staff will contact the patient to schedule an appointment.