

Patient Information Label or:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Infusion Center Referral/Order**

Admit to: Outpatient Infusion Center

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication/Procedure:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.