CENTRAL COAST INFUSION CENTER

917 Blanco Circle, Salinas CA 93901
phone 831-755-8157/fax 831-269-3611
www.ccinfusions.com

PATIENT INFORMATION **DATE:** _____

Name: _____ DOB: _____ Phone: _____

Primary Insurance: _____ Secondary: _____

REFERRING PHYSICIAN INFORMATION

Physician: _____ Contact Person: _____

Phone: _____ Fax: _____

INFUSION ORDERS

Actemra	Belatacept	Cerezyme	Cimzia	Entyvio
Fabrazyme	Feraheme	Gammagard	Gamunex-C	Injectafer
IVIG	Orencia	Prolia	Remicade	Rituxan
Simponi-Aria	Solu-Medrol	Tysabri		

Other drug: _____ How Soon: _____

***Will this be the first dose: Y or N If no, last dose received on: _____

***Dose & Frequency: _____

***ICD 10 code _____

***Physician's Signature _____

REQUIRED INFORMATION (***crucial info. for processing referral)

- Infusion Center referral form **or** referring physician signed order (including dose, frequency, diagnosis codes, etc.)
- Insurance card copies & demographics (including ht and wt), visit notes
- Pertinent labs, previous treatments tried (including why failed or discontinued)
- If the medical director approves the referral, our office will verify insurance(s), obtain authorizations and call pt to set up appt.