AOM Infusion
Improving Health, Enhancing Life

Infusion Referral Form (General)

Fax To: 800-528-9860
Phone: 800-746-9089
Website: aominfusionrx.com

Patient Demographic Information

Last Name:		First Name:	
Address:		Apt #:	
City:		State:	Zip:
Primary Phone:		Alt Ph or Email:	
Height:	Weight (kg):	Sex: ☐ Male ☐ Female	DOB:
Emergency Contact:		Phone:	

Insurance Information

Primary Insurance Provider:	Policy Number:
Phone Number:	Group:
Secondary Insurance Provider:	Policy Number:
Phone Number:	Group:
Employer Name:	Phone Number:

Diagnosis/General Information

Allergies: _____

Pertinent Clinical History _____

Please fill in the Diagnosis and ICD 10 Code for the infusion treatment:

_____

Patient Status (select one):

☐ New to therapy
☐ Continuation of therapy and last infusion day: _____

Please include the below information in the referral:

☐ Demographics
☐ Insurance Information
☐ Prescription/Order
☐ Labs
☐ Clinicals showing infusion need: i.e. progress notes, diagnostic labs/scans/ biopsy, tried and failed medication HX
☐ Additional Information

_____

Prescription Order

☐ **Infusion medication (include dosing, frequency, and other pertinent information)** ☐ Intravenous (IV) ☐ Subcutaneous injection (SC)

_____

Pre-Medication Order

Pre-Medication: Premedication and anaphylaxis kit per AOM Infusion protocol unless otherwise stated.

☐ Diphenhydramine ☐ PO or ☐ IV _____ mg, approximately 30 minutes prior to each infusion.
☐ Acetaminophen PO_____mg tablet, approximately 30 minutes prior to each infusion.
☐ Methylprednisolone IV_____mg, approximately 30 minutes prior to each infusion.
☐ Other _____ ☐ PO or ☐ IV, Strength _____ Directions _____
☐ Other _____ ☐ PO or ☐ IV, Strength _____ Directions _____
☐ None

☐ NS 500 ML bolus _____ Other _____ (in case 250 pre and 250 post) ☐ Pre-hydration ☐ Post hydration ☐ Pre and post hydration

Prescriber Information

Prescriber:			Office Contact Name:	
Clinic/Practice Name:				
Address:			City:	State: Zip:
Phone:	Fax:	License #:	UPIN #:	NPI:
Patient Last Name:		Patient First Name:		Patient DOB:

Prescriber Signature: _____ **Date:** _____

Substitutions permitted unless "No Substitution" is noted on this form.

By signing this form, you and your practice are consenting to receive communications from AOM Infusion. You authorize AOM Infusion to assist with prior authorization requests acting as your pharmacy provider in dealing with prescription and medical insurance organizations.

This form is not a valid order in the state of Arizona.

CONFIDENTIALITY NOTICE: The information contained in this communication and any additional attachments is confidential information or Protected Health Information (PHI) belonging to the sender and intended only for the use of the individual or entity named above. If you are not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this information in error, please notify AOM Infusion immediately at *(800) 556-4246* to arrange for the return or destruction of the original document.

Fax completed form, insurance information, and clinical documentation to: ***800-528-9860***. For any questions, please contact us at ***800-746-9089*** or visit our website ***aominfusionrx.com.***

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