

**NEW REFERRAL/INTAKE INFORMATION**

**THIS ADOBE PDF FORM IS A FILLABLE DOCUMENT**

**FAX THIS FORM TO CONTINUUMRX INSURANCE VERIFICATION:  
877-438-9380 (TOLL-FREE FAX) OR 865-934-0249 (LOCAL FAX)**

ALL INFORMATION IN THIS SECTION IS REQUIRED FOR INITIAL INSURANCE VERIFICATION

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Therapy Type(s): \_\_\_\_\_ Start Date: \_\_\_\_\_

Insurance #1: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Insurance #2: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Ordering MD: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Following MD: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Obtain Copies of the Following:**

- |  |           |                               |                      |
|--|-----------|-------------------------------|----------------------|
| _____ Demographic Sheet                      | _____ H&P | _____ Home Med List           | _____ MD DEA         |
| _____ Current Orders signed by Physician     |           | _____ Most Recent Lab Results | _____ Lab Orders     |
| _____ Pharmacy Providing Clinical Management |           | _____ Labs (Yes/No)           | _____ Therapy/Dosing |

**Additional Required Information:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Allergies \_\_\_\_\_

\_\_\_\_\_ Type of IV line (include number lumens) \_\_\_\_\_

\_\_\_\_\_ Estimated discharge date and date to start therapy \_\_\_\_\_ Duration \_\_\_\_\_

\_\_\_\_\_ Time Last Dose Given \_\_\_\_\_

\_\_\_\_\_ Follow-up Appointment \_\_\_\_\_

**Initial Delivery Location (Verify Delivery Address):**  Hospital  Room  Home  Other \_\_\_\_\_

**Ancillary Services:**

DME \_\_\_\_\_ Respiratory \_\_\_\_\_

HHA \_\_\_\_\_ PT \_\_\_\_\_ OT \_\_\_\_\_  
(Name of Agency/Location)

Other \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Referral Taken By: \_\_\_\_\_ Nurse Liaison: \_\_\_\_\_

Referral Name: \_\_\_\_\_ Referral Phone: \_\_\_\_\_