Phone: 888.304.1800 Fax: 877.865.9133

Quick referral form

option care™ | women's health

In partnership with COMMUNITY FIRST HEALTH PLANS

Please attach the following documents when you fax your referral:

Prenatal records | Lab reports | Insurance information | Demographics | PICC line confirmation (if applicable)

Option Care will fax back the PLAN OF TREATMENT for Providers Signature

Patient information

Full name _____ DOB _____ SSN _____ EDC _____

Address/City/State/Zip _____

Primary phone number _____ Secondary phone number _____

Primary language ☐ English ☐ Spanish ☐ Other _____

Primary insurance provider _____ ID number _____

Policy holder/Relationship to patient _____ DOB _____

Provider information

Physician/Provider name _____ NPI number _____ Contact person in office _____

Office phone number _____ Office fax number _____

Name of physician managing patients home care? _____

Is patient hospitalized ☐ YES ☐ NO (if so, please fill out below)

Hospital name _____ Hospital phone number _____ Hospital room number _____

Please check all services needed

Nausea and Vomiting Hyperemesis Program:

Therapy: ☐ Ondansetron pump ☐ Metoclopramide pump ☐ Total Parenteral Nutrition (TPN) ☐ Hydration

Route of administration: ☐ PICC line and maintenance (please send PICC line confirmation) ☐ Peripheral line

Prematurity Program:

Medication: ☐ Hydroxyprogesterone Caproate ☐ Makena® SQ (auto-injector) ☐ Other _____

Where would you like the medication sent? ☐ Patient home ☐ Provider office

Diabetes in Pregnancy Program:

☐ Diabetes in Pregnancy Program ☐ Insulin Program (provide patient with Rx for insulin)

Hypertension in Pregnancy Program:

☐ Hypertension in Pregnancy Program

Additional comments: _____

We appreciate your business! Please return the form either by Fax: 877.865.9133 or Email: OC-WH@optioncare.com

THE JOINT COMMISSION NATIONAL QUALITY APPROVAL

Submit