#### Phone: 888.304.1800 Fax: 877.865.9133

# Quick referral form

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	r			
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 n	umber		
Name of physician managing patients home care?				
Is patient hospitalized 🗌 YES 🗌 NO (if so, please fill out below)				
Hospital name Hospit	Hospital phone number		ospital 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: Route and maintenance (please send PICC line confirmation)		
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 Disulin 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



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