



Referral Intake Fax – 806.725.4942
Hours – 8:30 a.m. CST to 5:30 p.m. CST
For Immediate Assistance, please call
Covenant Home Infusion at 806.725.6327 or 800.283.6953

Home Infusion Therapy Fax Referral

Please complete and attach signed orders, current labs, history and physical, then fax to Covenant Home Infusion at the above number.

Covenant Home Infusion will call to confirm acceptance on service.

Referral Contact Name _____			
Phone _____		Fax _____	
<input type="checkbox"/> Hospital _____	<input type="checkbox"/> MD _____	<input type="checkbox"/> RN Agency _____	<input type="checkbox"/> Self _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Insurance _____	<input type="checkbox"/> Case Manager _____	

Patient Name _____		DOB _____	
SSN _____		Parent Details/Guardian _____	
Address _____		City, State, Zip _____	
Home Phone _____		Cell Phone _____	

INSURANCE: (Provide the following information, or attach photocopy of card, if available)

	Primary	Secondary
Subscribers Name		
Company		
Group Number		
ID #		
Pt. Relationship to Subscriber	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child Other: _____	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child Other: _____
Phone		

Primary Diagnosis _____	Height: _____
Secondary Diagnosis _____	Weight: _____
Allergies _____	
Access <input type="checkbox"/> None or <input type="checkbox"/> Type _____	Number of Lumens: _____

	Therapy 1	Therapy 2
Therapy Ordered	<input type="checkbox"/> Anti-Infective <input type="checkbox"/> Specialty Medication <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> IVIG <input type="checkbox"/> Pain Management <input type="checkbox"/> Parenteral Nutrition-Home Start <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	<input type="checkbox"/> Anti-Infective <input type="checkbox"/> Specialty Medication <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> IVIG <input type="checkbox"/> Pain Management <input type="checkbox"/> Parenteral Nutrition-Home Start <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other
Start of Care Date		
Length of Therapy		
Nursing Agency	Phone _____	<input type="checkbox"/> Referring <input type="checkbox"/> Assigned <input type="checkbox"/> To be Assigned <input type="checkbox"/> N/A

Prescribing Physician _____
Office Contact Person _____
Phone: _____ Fax: _____
Secondary Physician _____

CONFIDENTIALITY NOTICE

If faxed materials include Protected Health Information (PHI), these records are **CONFIDENTIAL**. Covenant Home Infusion shall receive Authorization from the patient prior to releasing or utilizing PHI for reasons other than treatment, payment or healthcare operations. This information is intended solely for the use of the individual named above. If you are not the intended recipient, you are hereby advised that any dissemination, distribution or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy the original fax message.