University Hospitals
Outpatient Specialty Clinics & Infusion Centers

Patient Label

NEW PATIENT REFERRAL FORM - ACUTE

Please fax this form with the requested information to patients preferred location**.** Allow 10 business days to obtain an authorization through the patient's insurance company. Once orders have been verified as complete and all clinical clearance criteria has been met, your patient will be called to schedule.

Patient Name:_____

Requested Therapy:_____

PROVIDER INFORMATION – PLEASE PRINT

Practice Name:_____

Prescriber Name:_____

Prescriber/Designee Direct Phone Number:_____

DOCUMENTATION NEEDED

- Completed Medication Order Set (pages 2-3)
- Documentation of lab/test results needed related to clinical clearance of requested medication
- Face sheet from current provider's office
- Copy of insurance cards if available
- ***If out of UH network include:***
  - ***Release of medical information***
  - ***Most recent office visit note***

SELECT PREFERRED LOCATION

☐ **NORTH RIDGEVILLE**
Cuyahoga County
Lorain County
32800 Lorain Road
Suite #1600
440-406-5510

☐ **WARRENSVILLE HEIGHTS**
Cuyahoga County
24865 Emery Road
Suite A
216-755-5380

☐ **CONCORD**
Cuyahoga County
Lake County
7590 Auburn Rd
Suite #207
440-354-1802

Thank you for choosing University Hospital's Outpatient Specialty Clinics and Infusion Centers, we look forward to providing exemplary care to your patients!

Sincerely,

The Staff of the UH Outpatient Specialty Clinics and Infusion Centers

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MEDICATION ORDER SET

All fields must be completed prior to submission. Incomplete orders will be returned to provider.

PATIENT INFORMATION

Name & DOB	
Address	
Phone	
ICD-10 CODE	
Height	
Weight	
Gender	
Allergies	

PRESCRIBER INFORMATION

Printed Name	
Address	
Phone	
Fax	
DEA	
NPI	
State License	

Prescriber Signature: _____ Date:_____

Printed Name: _____

This signed document serves as consent for prior authorization to be obtained by the UH Outpatient Specialty Clinics & Infusion Centers

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MEDICATION INFORMATION

Name of Drug	
Circle One	First Dose **OR** Continuation: last received on_____ Due On:_____
Dose	
Route	
Frequency	
Pre Treatment Parameters/Labs	
Premedications: PO or IV?	
Number of refills	
Substitutions allowed?	

NOTES/COMMENTS:

Prescriber Signature: _____ Date:_____

Printed Name: _____

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