Sarah Bush Lincoln

PATIENT INFORMATION

Name: _____ DOB: _____

Allergies: _____ Date of Referral: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*: SBL Infusion Services

☐ MATTOON
1000 Health Center Dr.
Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr.
Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

DIAGNOSIS AND ICD-10 CODE

Diagnosis: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information IF OUTSIDE SBLHC

☐ Clinical/Progress notes supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS

Please indicate medication, pre-medications, dose, route, and frequency:

_____

_____

_____

Refills: ☐ X 6 months ☐ X 1 year ☐ ____ doses

PRESCRIBER INFORMATION

Prescriber Name: (print) _____

Office Phone: _____ Office Fax: _____ Office Email: _____

Prescriber Signature _____ Date: _____ Time: _____

FAX COMPLETED FORM AND ALL DOCUMENTATION TO ABOVE OFFICE

SBL INFUSION SERVICES
REFERRAL FORM

Clinic Scan to: same location as attached documentation