QMEDRX
The Lyme Company

NEW PATIENT REFERRAL FORM

Referral Date:_____ Patient Name:_____

Date to begin therapy:_____ Date of Birth:_____

Telephone:_____

Referring Physician:_____ Telephone:_____

Fax:_____

Primary Care Physician:_____ Telephone:_____

Where does this physician have hospital privileges:_____

Diagnosis and IDC Codes:

□ 088.81 Lyme	□ 784.0 Headache	□ Other _____
□ 088.82 Babesia	□ 729.1 Myalgia	_____
□ 088.0 Bartonella	□ 348.3 Encephalopathy	_____
□ 082.40 Ehrlichia	□ 288.0 Neutropenia	
□ 438.0 Cognitive Problems	□ 719.49 Joint Pain	

Please FAX any additional information supporting the above diagnosis

IV Antibiotic Prescription:_____

Duration of therapy:_____

Administration route: Peripheral: _____ PICC:_____ Port:_____

Would you like Home Care Solutions to coordinate PICC/Port placement? _____ Yes _____ No

Will the patient receive first IV-ABX dose in your office administered by your staff? _____ Yes _____ No

Patient primary insurance:_____ Policy Number:_____

(Please fax copy of insurance card - both sides) Phone number:_____

Patient Secondary Insurance:_____ Policy Number:_____

(Please fax copy of insurance card - both sides) Phone number:_____

Has this patient ever received IV therapy for Lyme disease? _____ Yes _____ No

If yes - when? _____

In addition please fax : Patient Medication List: _____

Patient Demographics: _____ Positive Western Blot Results: _____

(Positive Western Blot results must be available before insurance coverage can be verified)

Home Care Solutions Pharmacy 888.273.9820 Fax: 877.644.3895

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