



PODIATRIC PATIENT REFERRAL FORM

Patient to participate in the **APMA** sanctioned outcome monitoring program? Yes No

Referral Date: _____ Patient Name: _____

Date to begin therapy: _____ Patient Telephone: _____

Referring Physician: _____ Date of Birth: _____

Fax: _____ Telephone: _____

Where does this physician have hospital privileges ? _____

Diagnosis and ICD 9 Codes

- | | |
|---|--|
| <input type="checkbox"/> Acute Osteomyelitis lower leg 730.06 | <input type="checkbox"/> Cellulitis of foot and ankle 682.7 |
| <input type="checkbox"/> Acute Osteomyelitis foot and ankle 730.07 | <input type="checkbox"/> Pyogenic arthritis foot and ankle 711.07 |
| <input type="checkbox"/> Acute Osteomyelitis multiple site 730.09 | <input type="checkbox"/> Arthropathy of foot and ankle 711.47 |
| <input type="checkbox"/> Chronic Osteomyelitis lower leg 730.16 | <input type="checkbox"/> Abscess post op of stitch or wound 998.59 |
| <input type="checkbox"/> Chronic Osteomyelitis foot & ankle 730.17 | <input type="checkbox"/> Surgical site infection 998.51 |
| <input type="checkbox"/> Chronic Osteomyelitis multiple site 730.19 | <input type="checkbox"/> MRSA 041.11 v 09.0 |

Other: _____

Please FAX additional information supporting the above diagnosis

IV Antibiotic Prescription: _____

Duration of therapy: _____

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

Would you like QMedRx 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 _____

In addition please fax : _____ Patient Demographics

_____ Patient Medication List

_____ Culture and Sensitivity Results