

# Sherwood Clinical Home Infusion Referral

Please complete the form below and Fax to 706-894-2808.  
If you prefer, you may call 1-800-847-3987 with your referral

**DATE & TIME OF REFERRAL:** \_\_\_\_\_ **TAKEN BY (initials):** \_\_\_\_\_ **SWC:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ (M \_\_\_ / F \_\_\_)

DOB: (MM/DD/YYYY) \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

**Current Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Allergies** \_\_\_\_\_

**Access type** \_\_\_\_\_ **Insertion Date** \_\_\_\_\_

**INSURANCE INFORMATION**

*Please provide a current copy of insurance card(s) or complete the following information.*

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB: (MM/DD/YYYY) \_\_\_\_\_ Insurance Co. Telephone # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB: (MM/DD/YYYY) \_\_\_\_\_ Insurance Co. Telephone # \_\_\_\_\_

**PRIMARY DIAGNOSIS:** \_\_\_\_\_ **ICD9 Code:** \_\_\_\_\_

Therapy	Start of Care	End date
1.		
2.		
3.		
4.		

**Patient's Hospital Room #:** \_\_\_\_\_

**NURSING CARE:** \_\_\_\_\_ **Sherwood Clinical** \_\_\_\_\_ **Other (specify)** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**PHYSICIAN INFORMATION**

Physician Name \_\_\_\_\_ NPI #: \_\_\_\_\_

GA License #: \_\_\_\_\_ UPIN #: \_\_\_\_\_ DEA #: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_ Office contact name \_\_\_\_\_ Ext \_\_\_\_\_

**Please note: At time of admission, Sherwood Clinical needs the following patient documents:**

**List of discharge medications**

**Current Lab Work**

**History & Physical**

**Physician Signature:** \_\_\_\_\_

**Date** \_\_\_\_\_

**Office Contact Name:** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Sherwood Clinical**  
415 Fisk Ave  
Demorest, GA 30535

**We will contact you for  
confirmation of received fax**

Sherwood Clinical will verify all insurance benefits with the insurance company(s) listed above prior to administration. The patient will also be notified prior to administration of any out of pocket expenses or co-payments.