NON-CANCER INFUSION CENTER INQUIRY FORM

SLU*Care* Des Peres Infusion Center **Fax: 314-977-7920** **Attn: Infusion staff** **Phone: 314-977-5401**
2325 Dougherty Ferry Road, Suite 102
Saint Louis, MO 63122

Thank you for the opportunity to participate in the care of your patient. Please complete this form and fax to the number listed above. After receiving this form we will send an **order form** that requires the ordering MD's signature and a **checklist** that is required for each patient's infusion. The checklist provides information our office needs to obtain a prior authorization.

1. Please print CLEARLY: **Ordering Physician's** First/Last Name: ____

2. Provide Contact Information for a staff person in order for us to send following required documents:

   Referring Office Contact Name: ____

   Referring Office Address (City, State, Zip): ____

   Contact Phone Number: _____________________________ Email: _______________________________________

   Fax Number: __________________________________

3. Patient Name: ____ DOB: ________________________________

4. Patient Telephone #1: ___________________________ Alternate Patient Telephone: _________________________

5. **Medication** needing to be infused: _____________________________________

   <u>Additional Requested Documentation:</u>

6. Please send copy of **Patient Registration Face Sheet** that lists patient's demographics.

7. Please send copy of **Front and Back of Current Insurance Card**.

8. Patient Diagnosis: ____ ICD-10 code(s): ______________________