Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.comHave a Question? (855) 478-1528

AVSOLA Referral

(- Required Fields)*

☐ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

New Referral **Referral Renewal** **Medication/Treatment Change**
Benefits Verification Only **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

AVSOLA Infusion*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ____________________
(required & specific as possible)

Initial/Reloading Dosing and then Maintenance Dosing:
_____mg/kg IV on day 0, 2, 6 weeks and every _____ weeks

Maintenance Dosing:
_____mg/kg IV every _____ weeks

ICD-10 Description:

Last Infusion/Injection Date: _____________

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ HepB Core (if available)
_____ HepB Surf Ag (w/in 36 months)
_____ TB Results (w/in 6 months)-if positive, need negative chest Xray and negative TSpot

STANDING LAB REQUEST (to be drawn by clinic): CMP CBC *Frequency_______________

Additional comments/notes:

Locations:

--------Colorado-------

___ Lakewood

--------Florida---------

___ Jacksonville
___ Kissimmee
___ Port St. Lucie
Suncoast
___ Winter Park

---------Ohio---------

___ Beachwood
___ Middleburg Hts.
___ Painesville
___ Youngstown
___ Westlake
Fairlawn

-------Oklahoma-------

Tulsa

---------Texas---------

Arlington
Cedar Hill
Dallas
Denton
Ft. Worth
Irving
Rockwall
Southlake
Flower Mound
Plano
Tyler

REVISION DATE- 5/2022