



Fax Referrals To: (855) 891-2191  
 Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) Have  
 a Question? (855) 478-1528

SOLU-MEDROL REFERRAL  
 (\* - Required Fields)

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

New Referral	Referral Renewal Benefits Verification Only	Medication/Treatment Change Discontinuation Order
<b>PATIENT INFORMATION</b>		
NAME*:		DOB*:
ADDRESS:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F
WEIGHT:      LBS   KG	HEIGHT:	EMAIL:
ALLERGIES:		
<b>PHYSICIAN INFORMATION</b>		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL (FOR UPDATES):
SOLU-MEDROL Infusion*: <i>(SELECT ONE OF THE FOLLOWING)</i>		ICD-10*:
Dosing: _____		
Frequency: _____		
Administration time: _____		
Physician Signature* _____		Date*(Referral Valid for One Year) _____
*NPI # _____		<i>Infusion will be administered per MPP policy and protocols</i>
<b>ICD-10 Description:</b>           <b>*STAT REASON:</b> (STAT requests will be assessed per MPP policy and protocols)	<b>REQUIRED DOCUMENTATION CHECKLIST:</b>  Patient Demographics  Insurance Card/Information  Progress Notes Supporting DX  Current Medication List and H&P	
Last Infusion/Injection Date: _____		
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