



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

IVIG 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*:
ADDRESS:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F
WEIGHT: LBS KG	HEIGHT:	EMAIL:
ALLERGIES:		
PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL (FOR UPDATES):
IVIG Infusion*: <i>(SELECT ONE OF THE FOLLOWING)</i> Gammagard Bivigam Octagam Asceniv Gamunex-C Privigen		ICD-10*: <i>(required & specific as possible)</i> Dosing: _____ Interval: _____
Physician Signature* _____		Date*(Referral Valid for One Year) _____
*NPI # _____		<i>Infusion will be administered per VIVO policy and protocols</i>
ICD-10 Description:	REQUIRED DOCUMENTATION CHECKLIST:	
*STAT REASON: (STAT requests will be assessed per VIVO policy and protocols)	Patient Demographics Insurance Card/Information Progress Notes supporting DX Current Medication List and H&P CMP (within last 3 months)	
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