

INFUSION REFERRAL FORM

DENT Tower
3980 Sheridan Drive
Amherst, NY 14226



DENT
NEUROLOGIC INSTITUTE

Sterling Medical Park
200 Sterling Drive
Orchard Park, NY 14127

Phone: (716) 250 – 2000 Fax: (716) 250 - 0960

GENERAL PATIENT INFORMATION

Date of Request ____/____/____ DOB ____/____/____ Age _____

Patient Name _____ Height: _____ Weight: _____

Patient SS# _____ Gender: Male Female

Address: _____

PATIENT INSURANCE INFORMATION

Primary Plan _____ Policy ID# _____

Home Phone #: _____ Alternate #: _____ Secondary _____ Policy ID# _____

REQUEST FOR TREATMENT

TREATMENT REQUESTED: _____

Dosage: _____ **Infusion Rate:** _____

PATIENT HISTORY

Past Medical History: _____

Current Medications: _____

Allergies: _____

Special Needs: _____

ORDERING PHYSICIAN CONTACT INFORMATION

Referring Physician: _____

Signature: _____

Phone Number: _(_____)_____ Fax Number: _(_____)_____

TREATMENT INFORMATION

To Be Completed by DENT Infusion Centers

Initial Appointment Date: ____/____/____ **Time:** ____:____ AM/PM **Initials:** _____

DENT Infusion Centers offer services for all of your patients infusion needs. Currently offering therapies for the treatment of Multiple Sclerosis, Headaches/Migraines, Neuromuscular Disorders, Oncology, Rheumatology, and Cardiovascular Disorders. Hydration as well as anti-emetic therapies are also available.