Merced Infusion Center

Mani Nallasivan, M.D.
424 E Yosemite Avenue, Suite A
Merced, CA 95340
Phone: (209) 349-8653 Fax: (209) 626-8144 or (209) 723-2516

"Your Infusion Solution"

Patient Referral/Rx

Patient Name: _____ DOB:_____

Address: _____ City: _____

State: _____ Zip Code: _____

Cell Phone: _____ Alternate Phone: _____

Insurance: _____ Authorization # _____

Referring Physician Information:

Name:_____

Phone Number: _____ Fax Number: _____

Reason for referral:

- ☐ Infusion Service -Drug Ordered: _____

  _____ Frequency _____

  - Biosimilars substitution allowed.
  - DAW

- ☐ Diagnosis: _____ ICD-10: _____

- ☐ Other: _____

_____ _____ _____

Ordering Physician Name (Print) **Ordering Physician Signature** **Date**

Please include:

- Copies of any recent labs, progress notes, and current medication list.
- Copies of any pertinent testing related to treatment being requested.
- Copies of current insurance cards & patient demographics.
- This order EXPIRES 12months from date of signed, unless otherwise specified.

Please call our office if you have any questions.

(209) 349-8653