

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 _____
- ☐ 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.

Please call our office if you have any questions.

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