



Phone: 732-390-7750 Fax: 844-683-2244

AsteraCancerCare.org

PATIENT REFERRAL FORM

GASTROENTEROLOGY

Patient Name: Last First Middle Pt. DOB: / /

Patient Address:

Patient City: Pt. State: Pt. Zip:

Patient Phone: () - Pt. Height: in.

ICD-10 Code(s): Pt. Weight: lbs.

Patient Allergies:

Insurance: ID#:

Referred by: NPI#:

Office Contact (Required): Office Ph: () -

Office Fax: () -

Office Administrator (Required): Administrator Ph: () -

Astera Infusion Services scheduling location request: Brick Bridgewater East Brunswick Edison

Jersey City Monroe Parsippany Robbinsville Rutherford Somerset Toms River

Required Items/Infusion Process:

Valid/signed written prescription including name of medication, exact dosage, and directions (prescription only valid for 6 months, including refills)

Copy of current insurance card

Recent MD consultation notes: relevant disease being treated must be mentioned in report

Allergies and current medication list

Current labs required for specific medication, as noted on the following page(s) of this form

Has the patient initiated treatment at your office? Yes No

If any future lab tests are needed, please provide patient with a prescription, and have patient bring on day of treatment. Results will be sent to referring physician.

Please note:

- 1. A Letter of Medical Necessity is required for all patients receiving their initial infusion at Astera...
2. Benefit investigations, copay assistance and prior authorizations will be handled by the Astera precert staff...
3. A pretreatment education session will be provided by an Advanced Practice Provider.
4. Once the infusion is complete, a follow-up notice will be faxed to the to the referring provider.

