At St. Mary’s, we appreciate the ever changing world of healthcare and value efficient, time-saving tools. We have created this document as a reference for your office. You may also obtain the most current information at the following link: www.stmarys.org/referral

For Further Information, Please Contact:

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searhart@stmarys.org

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## St. Mary’s Services

<table>
<thead>
<tr>
<th>Office</th>
<th>Procedure</th>
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</table>
| **Cardio-Pulmonary Rehab**  
St. Mary’s Heart Institute  
P: 812.485.5230  
F: 812.485.5234 | Inpatient and Outpatient Cardiac Rehab  
Pulmonary Rehab  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:**  
St. Mary’s Outpatient Cardiac Rehab (2nd floor Center for Advanced Medicine) |
| **Center for Children**  
St Mary’s Center for Children  
*Referral navigator assistance available for every pediatric referral, even if services are not available locally.*  
P: 812.485.7425  
F: 812.485.7678 | Will accept faxed referral form or EHR with the following items included.  
Include:  
- Your latest office note about the referral problem  
- Growth charts  
- Laboratory testing results  
- Imaging or radiology reports (last 6 months)  
- Endoscopy/pathology allergy reports (for GI referrals)  
- Operative/pathology reports  
- Legible insurance card  
CFC will contact parent directly in 3-5 business days.  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:** SMMC Center For Children |
| **Endocrinology / Dr. Vishal Bhatia**  
P: 812.485.1400  
F: 812.485.1401 | Please call to schedule appointment.  
No referral form or physician order required.  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:** evaendoreferrals  
Bellemeade Ave. Ste 110 |
| **Imaging / Radiology Services**  
St. Mary’s Scheduling | Please call to schedule appointment, or fax order.  
**How to refer in Athena:** St. Mary’s Scheduling |
| **Lab Services**  
[www.stmarys.org/lab-resources](http://www.stmarys.org/lab-resources)  
St. Mary’s Scheduling | Please call to schedule appointment, or fax order.  
**How to refer in Athena:** St. Mary’s Scheduling |
| **Maternal-Fetal Medicine and Genetics Center** | Preferred method: Please call the MFM office to secure a date and time of the appointment, then fax pertinent information. Will accept faxed referral form or EHR with the following items included. Include:  
- Prenatal records  
- Labs  
- All previous ultrasounds  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:** SMMC Maternal Fetal Medicine |
| **Medical Equipment (DME)** | Will accept faxed order with referral form or EHR order with the following items included.  
Oxygen:  
- Qualifying/titration information  
- Device, Liter Flow, Hours of daily use  
*Medical Necessity forms required for matriarch brace and rachis back brace.*  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:** St. Mary's DME Supply |
| **Nephrology Associates** | Will accept faxed referral with referral form or EHR with the following items included. Include:  
- Most recent office notes  
- Lab test results  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:** evanehprefsreferrals |
| **OB/GYN** | Preferred method: Please call the office to secure a date and time of the appointment, then fax pertinent information. You may also simply fax referral.  
Fax previous office visit and include pertinent lab, imaging, cytology, and pathology reports  
**How to refer in Athena:**  
SMMG Partners in Women’s Health  
SMMG Henderson Partners in Women’s Health  
Herman L Reid |
| **SMMG Cardiology** | Please call to schedule appointment, or fax referral.  
**How to refer in Athena:** evacardioreferrals |
| **St. Mary’s at Home** | Please call for requests.  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:** St. Mary’s at Home |
| **St. Mary's Breast Center** | Please call to schedule appointment for screening. If patient is experiencing clinical symptoms or provider indicates diagnostic mammogram, please fax the order or send the order with the patient.  
**How to refer in Athena:** St. Mary's Breast Center |
|-----------------------------|--------------------------------------------------------------------------------------------------|
| **St. Mary's Infusion Center** | Infusion Center accepts patients from physicians on St. Mary’s Medical Staff. Order is Required.  
**How to refer in Athena:** St. Mary’s Infusion Center |
| **St. Mary's Dietitian** | Please call to schedule appt or fax order.  
*Please send reason for the referral (i.e. last chart note, labs, etc).*  
**How to refer in Athena:** St. Mary’s Scheduling |
| **St. Mary’s Pulmonary Care / Lung Nodule Clinic** | Will accept faxed referral form or EHR with the following items included.  
**Include:**  
Reason for referral  
Chest X-rays and/or CT  
Hospital Records including Admission/Discharge Summary  
Most recent EKG and/or Echocardiogram  
Recent labs/pathology reports  
H&P and recent office notes for past 6 months  
Current medication list  
Allergy and Immunization list  
Pulmonary Function Tests/Spirometry/Pulse Ox/6 minute walk  
Cardiac Testing (Stress test, heart catheterization)  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:** evapulmreferrals |
| **St. Mary’s Outpatient Rehab (Physical Therapy, Occupational Therapy, Speech Therapy)** | Will accept faxed order with referral form or EHR referral order.  
For site specific questions, call:  
Washington Square: 812.485.5200  
North Pointe: 812.485.6910  
Main Campus:812.485.4521  
Hydrotherapy  
Modified Barium Swallow  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.  
**How to refer in Athena:**  
St. Mary’s Rehab OP Washington Square Mall |
<table>
<thead>
<tr>
<th><strong>St. Mary’s Rheumatology Care</strong></th>
<th>Will accept faxed referral form or EHR with the following items included. Include:</th>
</tr>
</thead>
</table>
| **P: 812.485.6030**  
**F: 812.485.6032** | Reason for referral  
Recent labs (last 6 months)  
Recent office visit notes  
Current medication lists  
Allergy lists  
Diagnosis list  
History and Physical |
| **Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.** | **How to refer in Athena:** [evarheumreferrals](http://www.stmarys.org/referral) |

<table>
<thead>
<tr>
<th><strong>St. Mary’s Sleep Disorders Center</strong></th>
<th>Referral form required.</th>
</tr>
</thead>
</table>
| **P: 812.485.7680**  
**F: 812.485.7576** | **Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.** |
| **How to refer in Athena:** | **EVA Sleep Referrals** |

<table>
<thead>
<tr>
<th><strong>St. Mary’s Warrick Rehabilitation Services</strong></th>
<th>Please see <a href="http://www.stmarys.org/referral">www.stmarys.org/referral</a> for order forms.</th>
</tr>
</thead>
</table>
| **P: 812.897.7158**  
**F: 812.897.7361** | **How to refer in Athena:**  
**St. Mary’s Warrick Rehabilitation Services** |

<table>
<thead>
<tr>
<th><strong>St. Mary’s Medical Group Urology</strong></th>
<th>Please see <a href="http://www.stmarys.org/referral">www.stmarys.org/referral</a> for order forms.</th>
</tr>
</thead>
</table>
| **P: 812.473.1111**  
**F: (812) 485-2461** | **How to refer in Athena:**  
**evaurologreferrals** |

| **St. Mary’s Weight Management Center** | Referrals are accepted in multiple ways:  
*Provider calls for appointment  
*Patient calls for appointment  
*Will accept faxed referral or EHR with the following items included.  
Weight Management will schedule appointment with patient directly.  
Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms. |
|---|---|
| ***Surgical Program**  
**P: 812.485.5858**  
**F: 812.485.5815** | **How to refer in Athena:**  
**SMMC Weight Management Center** |

<table>
<thead>
<tr>
<th><strong>St. Mary’s Women’s Physical Therapy</strong></th>
<th>Will accept faxed referral form or EHR with the following items included. Include:</th>
</tr>
</thead>
</table>
| **P: 812.485.5725**  
**F: 812.485.5724** | Diagnosis code and order  
Patient Demographics |
| **Please see [www.stmarys.org/referral](http://www.stmarys.org/referral) for order forms.** | **How to refer in Athena:**  
**St. Mary’s Women’s Physical Therapy** |

<table>
<thead>
<tr>
<th><strong>St. Mary’s Wound Care Clinic</strong></th>
<th>To schedule an appointment, call 812.485.7330.</th>
</tr>
</thead>
</table>
| **P: 812.485.7330**  
**F: 812.485.4679** | **How to refer in Athena:**  
**St. Mary’s Wound Care Clinic** |
Outpatient Cardiac Rehab-Phase II Referral Form
3700 Washington Ave
Evansville, IN 47750

Patient Name: __________________________ Date of Birth _______________________

Diagnosis Date: ___________________ Patient phone number: _______________________

Please describe correct diagnosis below:

1. **CABG** (specify vessels)
   __________________________________________________________________________
   __________________________________________________________________________

2. **Valve replacement** (specify valve) __________________________________________

3. **Valve Repair** (specify valve)______________________________________________

4. **PTCA/Stent** (specify vessels)______________________________________________

5. **Stable Angina**___________________________________________________________

6. **MI** (specify location: i.e. anterior, inferior, etc.) _____________________________

7. **MI > 8 weeks old** (specify location: i.e. anterior, inferior, etc.) ________________

8. **Stable Chronic Heart Failure** (Please note qualifiers below. Must answer “yes” to all
   3 and complete qualifiers to be eligible)
   
   1. **EF of 35% or less** YES/NO    EF%_________ Date__________
   
   2. **NYHA class II-IV symptoms** despite being on optimal heart therapy for at least 6
      weeks    YES/NO    Current NYHA class____________
   
   3. **Must not have had recent (< 6 weeks) or planned (< 6 months) major
      cardiovascular hospitalizations or procedures** YES/NO

9. **Other diagnosis** ______________________ (may be covered by insurance)

Referring MD: __________________________ Fax Number: _______________________

May institute chest pain standing order/protocol which includes nitroglycerin and oxygen.

Patient may begin Phase II Outpatient Cardiac Rehabilitation

Physician Signature __________________________ Date: _______________________

Please return via fax (812) 485-5234. Phone: (812) 485-5230

7105-75 8.10.15
Outpatient Pulmonary Referral Form

Patient Name: ________________________________ DOB: _____________

Insurance Name and Policy #: ___________________________

Patient phone number: ________________________________

Diagnosis: Please select the appropriate diagnosis below and include description of severity of disease:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Specify:</th>
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<tbody>
<tr>
<td>Sarcoïdosis</td>
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<tr>
<td>Cystic Fibrosis</td>
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<tr>
<td>Chronic bronchitis</td>
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<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Bronchiectasis</td>
<td></td>
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<tr>
<td>COPD - GOLD STAGE</td>
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<tr>
<td>Coal worker’s pneumoconiosis</td>
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<tr>
<td>Asbestosis</td>
<td></td>
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<tr>
<td>Pneumoconiosis</td>
<td></td>
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<tr>
<td>Post-inflammatory pulmonary fibrosis</td>
<td></td>
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<tr>
<td>Idiopathic pulmonary fibrosis</td>
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<tr>
<td>Lung Transplant</td>
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</tbody>
</table>

Other diagnosis not specified above: __________________________________________________________

Is patient currently using home oxygen?   YES     NO

Prescribed Flow Rate of O2: at Rest _____ L/Min.  *with Activity _______ L/Min

If yes, can we attempt to wean patient off oxygen?   YES     NO

Oxygen saturation limit for exercise? _____ %

Can oxygen be applied to maintain saturation limit prescribed above?   YES     NO

If patient develops chest pain, may we administer nitroglycerine/oxygen per chest pain protocol?   YES     NO

Other medical conditions affecting patient’s ability to exercise: (please list)

__________________________________________________________

MD signature: ____________________________ Date: _____________

Please fax demographics, insurance, office notes, and most recent PFTs. Thank you.

St. Mary’s Outpatient Pulmonary Rehabilitation Program.


7105-41  Rev. 8/15 pulmonary referral form
Outpatient Pulmonary Referral Form-Phase III

Date: ______________

Patient Name: ___________________________________________ DOB: _______

Address: _________________________________________________

Phone number: Home__________________________ Cell________________________

Diagnosis:_____ Patient may begin Phase III Outpatient Pulmonary Rehabilitation

Is patient currently using home oxygen? YES NO

If yes, may we attempt to wean patient off oxygen? YES NO

Prescribed flow rate of oxygen at rest:

_________L/min. with activity

_________L/min. Oxygen saturation limit for exercise

_________%

If patient develops chest pain may we administer Nitroglycerine/oxygen per the chest pain protocol? YES NO

Other medical conditions affecting patient’s ability to exercise: (please list)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

MD Signature__________________________________________________________

Please fax demographics, History and Physical, office notes, and most recent PFTs.

Thank you for this referral.

St. Mary’s Outpatient Pulmonary Rehabilitation Program

PHYSICIAN REFERRAL FOR AT-RISK OR PHASE III PROGRAM

Date: _______________

Patient’s Name: ___________________ DOB: ______________

Phone Number: ____________________

Diagnosis: _________________________

Other Medical History: ______________________________________________________

Please list any cardiac risk factors:

_____ Smoking

_____ Hyperlipidemia

_____ Obesity

_____ Family History

_____ Lack of Exercise

_____ Hypertension

_____ Diabetes

_____ Stress

_____ PVD

_____ CHF

May institute chest pain standing order/protocol which includes nitroglycerine and oxygen.

Physician Name: _______________________

Physician Signature: ___________________ Date: _____________

Please send a copy of the most recent H & P, medication list, and office visit. Fax to: 485-5234

7105-72 07/2011
** Fax relevant documents below to FAX # 812-485-4849

Reason for referral

<table>
<thead>
<tr>
<th>Patient First Name</th>
<th>MI</th>
<th>Last Name</th>
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<th>Date of Birth</th>
<th>Sex</th>
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<td>M</td>
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<td>F</td>
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</table>

Name of Parent/ legal guardian/foster parent *(please circle status)*

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<tr>
<th>Mailing address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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Contact phone numbers

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<tr>
<th>Home</th>
<th>Cell</th>
<th>Work</th>
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OFFICE CONTACT NAME

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<tr>
<th>Source Referral/Agency</th>
<th>Address</th>
<th>Office phone (    )</th>
<th>FAX (    )</th>
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Fax legible front and back of card and info below.

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<tr>
<th>Name of Primary Insurance</th>
<th>Benefits telephone #</th>
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<tr>
<th>Insurance subscriber/policy holder name</th>
<th>Policy holder DOB</th>
<th>Policy holder Social Security #</th>
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<tr>
<th>ID #</th>
<th>Subscriber Employer</th>
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<tr>
<th>Name of Secondary Insurance</th>
<th>Benefits telephone #</th>
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<table>
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<tr>
<th>Insurance subscriber/policy holder name</th>
<th>Policy holder DOB</th>
<th>Policy holder Social Security #</th>
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<tr>
<th>ID #</th>
<th>Subscriber Employer</th>
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</table>
Pediatric Sleep Disorder Services

Referring physician’s printed name: ____________________________ Office telephone: ____________________________

DX question: ____________________________ Fax #: ____________________________

**PLEASE FAX COMPLETED FORM with HISTORY & PHYSICAL or recent OFFICE NOTES and copy of INSURANCE CARD.** Patient will be scheduled for sleep study when information is received from your office and we will fax appointment to your office.

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>DOB / /</th>
<th>Age</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Phone</td>
<td>Alt phone</td>
</tr>
</tbody>
</table>

☑️ **ALL PATIENT PROBLEMS**

- [ ] Behavior / academic problems
- [ ] Bedwetting
- [ ] Choking/gasping
- [ ] Chronic fatigue
- [ ] Difficulty initiating sleep
- [ ] Excessive daytime sleepiness
- [ ] Family hx sleep problems
- [ ] Frequent awakenings
- [ ] Grinding teeth
- [ ] Insomnia
- [ ] Morning headaches
- [ ] Nightmares
- [ ] Night sweats
- [ ] Narcolepsy
- [ ] Obsessive compulsive disorder
- [ ] Other sleep disturbance
- [ ] Restless legs
- [ ] Sleep talking
- [ ] Sleep walking
- [ ] Snoring
- [ ] Witnessed apnea
- [ ] Weight loss / gain

☑️ **INFANTS ONLY:**

- [ ] Premature
- [ ] Gestational age _____ weeks
- [ ] Craniofacial malformation
- [ ] BPD
- [ ] Neuromuscular Disease

**MEDICAL HISTORY**

- [ ] Asthma
- [ ] Allergies
- [ ] Anxiety / Depression
- [ ] ADHD
- [ ] Cardiac problems
- [ ] Craniofacial malformation
- [ ] Chronic sinusitis
- [ ] Diabetes
- [ ] Deviated septum
- [ ] Enlarged adenoids
- [ ] Enlarged tonsils
- [ ] Enlarged tongue
- [ ] GERD
- [ ] Hypertension
- [ ] Hx of Seizures
- [ ] Nasal obstruction
- [ ] Small pharyngeal inlet
- [ ] Obesity
- [ ] Previous T/A Date ________
- [ ] Thyroid disease
- [ ] Modified Barium Swallow
- [ ] X-ray / MRI/ CT Head/Neck

**PAST PROCEDURES**

- [ ] EEG
- [ ] Pulmonary Function Test
- [ ] Bronchoscope

**PATIENT’S SPECIAL NEEDS**

- [ ] Oxygen? _____ LPM
- [ ] Breathing Tx’s
- [ ] Aerosol Tx Yes/No
- [ ] Tracheotomy
- [ ] Special feedings? N/G O/G G-tube
- [ ] Wheelchair
- [ ] Autism
- [ ] Developmental delay
- [ ] Down’s syndrome
- [ ] Cerebral palsy
- [ ] Toddler Bed
- [ ] Bedrails Y or N
- [ ] Sleeps with parent
- [ ] Bedtime: ______
- [ ] Weekday Rise Time: ______
- [ ] Allergic to: ____________________________

**SLEEP ENVIRONMENT**

- [ ] Crib
- [ ] Toddler Bed
- [ ] Down’s syndrome
- [ ] Sleeps with parent

**CURRENT MEDICATIONS**

- [ ] Bedtime: ______

**ALLERGIES**

- [ ] NKDA
- [ ] Latex allergy
- [ ] Tape allergy

**ADDITIONAL INFORMATION:**

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*Note: This form is part of the Pediatric Sleep Disorder Services at ST. MARY’S CHILDREN’S.*
Date: ____________

We will call patient to schedule appointment.

---

**Referral / Order Form for Diabetes Education**

*Fax referral/order to 812-485-1804***

---

**Patient:** ________________________________

**Home Phone:** ________________________________

**Address:** ________________________________

**DOB:** ________        **SSN:** ________________

---

**Service Requested:** (Please check all that apply)

- □ Diabetes Training (DSME – Diabetes Self-Management Education encompasses 10 hours of self management training and diet). Medicare allows 10 hours DSME in 12 month period, plus 2 hours follow up annually.

  Please specify # of hours education requesting if different from the routine 10 hours _______

- □ Medical Nutritional Therapy (MNT – Medical Nutritional Therapy encompasses 3 hours in the first calendar year, plus 2 hours of follow up annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis)

  _____Initial MNT _____ annual Follow- up MNT

Diabetes Self-Management Education (DSME) and Medical Nutritional Therapy (MNT) are individual and complimentary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT and DSME improves outcomes.

---

Please indicate any special needs requiring individual Education:

- Vision ___ Hearing ___ Language____

- Cognitive Impairment ___ Other ________________

---

**Other Special Service Requested** (Please check)

- □ Gestational Diabetes Training

- □ Insulin Administration Instruction

- □ Type ____________________________

  Dosage ____________________________

- □ Insulin Pump Training

- □ CHO counting

- □ Annual Update – 2 hours

- □ Pre-diabetes Class

- □ Other ____________________________

---

**Diagnosis:**

- □ Type 2 Diabetes

- □ Type 2 Diabetes, uncontrolled

- □ Pre-diabetes/Impaired Fasting Glucose

- □ Abnormal Glucose Tolerance

- □ Type 1 Diabetes

- □ Type 1 Diabetes, uncontrolled

- □ GDM Gestational Diabetes

- □ PCOS

- □ Preexisting DM w/ pregnancy (Type ______)

- □ Other ________________

---

To assist us in assessing your patient, please check any of the following that apply:

- □ Newly diagnosed/ Never had training

- □ New to insulin or oral agent

- □ Elevated A1C

---

**PLEASE INCLUDE RECENT LAB RESULTS FOR GLUCOSE, HGBA1C, LIPID PROFILE**

**MD Signature:** __________________________________________

**MD Name (print):** __________________________________________

**MD phone:** ___________________   **MD fax:** ___________________

---

Referral for Diabetes Self Management Training: I certify that DSME services are needed under a comprehensive plan for this patient’s diabetes care for the reason(s) listed above. I understand that patient reports will be sent at the end of the class series and after subsequent follow-up visits.
**Referral / Order Form for Diabetes Education**

******Fax referral/order to 812-485-1804******

We will call patient to schedule appointment.

<table>
<thead>
<tr>
<th>Service Requested: (Please check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Diabetes Training (DSME – Diabetes Self-Management Education encompasses 10 hours of self management training and diet). Medicare allows 10 hours DSME in 12 month period, plus 2 hours follow up annually. Please specify # of hours education requesting if different from the routine 10 hours ______</td>
</tr>
<tr>
<td>□ Medical Nutritional Therapy (MNT – Medical Nutritional Therapy encompasses 3 hours in the first calendar year, plus 2 hours of follow up annually. Additional MNT hours available for change in medical condition, treatment and / or diagnosis) ______Initial MNT _____ annual Follow- up MNT</td>
</tr>
</tbody>
</table>

Diabetes Self-Management Education (DSME) and Medical Nutritional Therapy (MNT) are individual and complimentary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT and DSME improves outcomes.

Please indicate any special needs requiring individual education:

- Vision ___ Hearing ___ Language ___
- Cognitive Impairment ___ Other ______________

**Other Special Service Requested (Please check)**

- □ Gestational Diabetes Training
- □ Insulin Administration Instruction
- □ Type ____________________________
- □ Dosage ____________________________
- □ Insulin Pump Training
- □ CHO counting
- □ Annual Update – 2 hours
- □ Pre-diabetes Class
- □ Other ______________________________

To assist us in assessing your patient, please check any of the following that apply:

- □ Newly diagnosed/ Never had training
- □ New to insulin or oral agent
- □ Elevated A1C

**PLEASE INCLUDE RECENT LAB RESULTS FOR GLUCOSE, HGBA1C, LIPID PROFILE**

<table>
<thead>
<tr>
<th>MD Signature: ______________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD Name (print): __________________________________________</td>
</tr>
<tr>
<td>MD phone: ___________________________  MD fax: ______________</td>
</tr>
</tbody>
</table>

Referral for Diabetes Self Management Training: I certify that DSME services are needed under a comprehensive plan for this patient's diabetes care for the reason(s) listed above. I understand that patient reports will be sent at the end of the class series and after subsequent follow-up visits.
Referring Physician: ___________________________ Today’s Date: _________________________
Office Address: ___________________________________________ PCP: ___________________________
____________________________________________________________________________________
Phone Number: __________________________________________________________
Fax Number: _________________________________________________________________

Patient Name ___________________________ DOB: _______ SSN#: ______________________
                          Last             First
Address: ___________________________________________ City: ___________________ State_____ Zip_____
Phone Number: ___________________________ Home ___________________________ Cell/Other
Insurance: ___________________________ ID # ____________ Group # ____________ Policyholder: __________

*****PLEASE INCLUDE A COPY OF PATIENT’S INSURANCE CARD*****

*****PLEASE FAX PRENATAL RECORD, LABS, AND ALL PREVIOUS ULTRASOUNDS*****

G: _____ P: _____ EDC: ________________ Gestational Age Today __________________________ (weeks)

Indication for Consultation: ____________________________________________________________

(REQUIRED)

SERVICES NEEDED:

_____ Physician Consultation with Level II Ultrasound                      _____ Level II Ultrasound ONLY

_____ Preconception Consult with MD & Genetic Counselor                     _____ BPP

_____ Genetic Counseling Consult                                             _____ Fetal Echocardiogram

_____ First Trimester Screen                                                _____ NST

_____ Amniocentesis -Genetic or Lung Maturity

_____ Other ______________________________________________________________

_____ Notify referring office of appointment date and time so patient can be informed.

_____ Contact the patient with appointment date, time, and inform referring office.

Appointment Date/Time______________________________ Appointment Scheduled by: __________
Physician’s Detailed Written Order for Medical Equipment

Patient’s Name: ____________________________ Date of Birth __________________________

Date of Order: ______________ Height: ________ Weight: __________

Prescribing Provider’s Name: ____________________________ Diagnosis: __________________________

Prescribing Provider’s NPI Number: __________________________

Description of Item:

☐ Nebulizer Compressor & Supplies Length of Need? __________
☐ Semi-Electric Hospital Bed Length of Need? __________
☐ Heavy Duty Hospital Bed Length of Need? __________
☐ Patient/Hoyer Lift Length of Need? __________
☐ Manual Wheelchair Standard Length of Need? __________
☐ Manual Wheelchair Lightweight (medical necessity must apply) Length of Need? __________
☐ Manual Wheelchair Heavy Duty (medical necessity must apply) Length of Need? __________
☐ Elevating Leg rests for wheelchair (medical necessity must apply) Length of Need? __________

☐ Oxygen per: ☐ Concentrator or ☐ Liquid

Oxygen per: ☐ Nasal Cannula ☐ Trach Mask ☐ Simple Mask

Continuous @ _____ LPM with Exertion @ _____ LPM Nighttime/Sleep only @ _____ LPM

Need portability: ☐ Yes or ☐ No Is patient mobile in the home? ☐ Yes or ☐ No

Needs conserving device: ☐ Yes or ☐ No PRN Spot check for SpO2? ☐ Yes or ☐ No

O2 Contents _____ (Please check for when patient’s rental reaches cap)

Duration of use: ☐ Lifetime OR (# of) ____ Months OR (# of) ____ Weeks

(Reevaluate as needed)

Signature of Physician: ____________________________ Date: ______________

Effective January 1, 2014, a face to face examination must document that the patient was evaluated and/or treated for a condition that supports the need for the items ordered. If this is conducted by a provider other than the physician, the physician must co-sign the evaluation. The most recent face to face (attached) was completed on _____________________________.

17
This letter documents the medical necessity for the PPI Matriarch™ Back Brace and can provide empirical evidence for its efficacy with regard to this patient’s condition. As prescribed, the Matriarch™ will assist in pain control by dispersing the weight of the abdomen while helping to stabilize the patient in a neutral spinal position. The brace comes standard with two adjustable cinching straps allowing the lower strap to anchor the brace to the body while the upper strap maintains positioning of the abdomen without causing an increase in pressure over the fetus. This positioning will form a “shelf” to help support the abdomen and spread the additional weight associated with the pregnancy across the entire spine as well as through the rigid posterior panel, thus allowing a more neutral spinal position and the subsequent elimination of back pain associated with a hyperlordotic posture. The brace itself is made of a lightweight / breathable material designed to provide the appropriate amount of stabilization while still allowing movement to promote activity and combat the muscle atrophy associated with movement restriction. It is my professional opinion that without this brace, the patient is subject to further increases in pain and limitations of activity that could further complicate the pregnancy and minimize patient function.

◊ PPI Matriarch™: ________ L0631

_____________________________  _________________________
Physician Signature              Date
Letter of Medical Necessity, For PPI Rachis Back Bracing System

Detailed Written Physician Order, Prescription, Letter of Medical Necessity

__________________________
Date

__________________________   ____________________________
Patient's Name               DOB

__________________________
Diagnosis

This letter documents the medical necessity for the Rachis Back Brace and can provide empirical evidence for its efficacy with regard to this patient's condition. As prescribed, the Rachis has effective compression coupled with the capability for hot/cold gel inserts to assist in pain control. The brace also comes standard with 4 cinch straps to facilitate the appropriate amount of support both circumferentially as well as accommodating varying amounts of lumbar curvature to maximize both function and compliance. The brace itself is made of a lightweight / breathable material and is designed to provide stabilization while still allowing movement to promote activity and combat the muscle atrophy associated with movement restriction. It is my professional opinion that without this brace, the patient is subject to further injury that could require prolonged rehabilitation.

◊ 9” Rachis (L0627)
◊ 12” Rachis (L0631)

__________________________
Physician's Name:

__________________________
Address:

__________________________    _______________    ____________
City: State: Zip: 

Phone: Fax:

__________________________   ____________________________   ____________________________   ____________________________
Physician's Signature               NPI#                   UPIN#                   Date
INCOMING REFERRAL
Please return with office notes and lab test results

PATIENT NAME: ________________________________

ADDRESS: ________________________________________
__________________________________________________

PHONE: (H) ________ (W) ________________ (C) __________

DOB: ___________________ SS#: ___________________

DIAGNOSIS: _______________________________________

INSURANCE INFO: PRIMARY: _______________________
SECONDARY: _______________________

IS PRECERT REQUIRED? YES NO

REFERRING PHYSICIAN: ____________________________

SPECIALTY: ______________________ NPI: _______

PHONE: _______________________________

OFC CONTACT PERSON: _______________ FAX: __________

PHYSICIAN ADDRESS: __________________________

PHYSICIAN PREFERENCE? ___________________________

APPOINTMENT DATE / TIME: __________________________

APPOINTMENT WITH: __________________________

SET UP BY: ___________ INFO SENT: ___________ DATE: ___________

ACCOUNT # ____________________________
**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>S.S.</td>
<td>#__ __ __ / __ __ / __ __ __ __</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>( __ __ __ ) __ __ __- __ __ __ __</td>
</tr>
<tr>
<td>Primary Insurance</td>
<td></td>
</tr>
<tr>
<td>Policy #</td>
<td></td>
</tr>
<tr>
<td>Secondary Insurance</td>
<td></td>
</tr>
<tr>
<td>Policy #</td>
<td></td>
</tr>
<tr>
<td>Emergency Contact Name</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>( __ __ __ ) __ __ __- __ __ __ __</td>
</tr>
<tr>
<td>Surgery Date</td>
<td></td>
</tr>
<tr>
<td>PMH</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
</tbody>
</table>

**INCLUDE THE FOLLOWING WITH THIS FAX:**
1. LIST OF MEDICATIONS  
2. LAST-VISIT DOCUMENTATION  
3. LAST HGBA1C WITHIN 3 MONTHS FOR TYPE II DM

**ORDERS**

- [ ] SKILLED NURSING
- [ ] PHYSICAL THERAPY
- [ ] OCCUPATIONAL THERAPY
- [ ] SPEECH THERAPY
- [ ] MEDICAL SOCIAL WORKER
- [ ] HOME CARE AIDE

**LAB ORDERS**

**WOUND CARE ORDERS**

**OTHER**

**FACE-TO-FACE ENCOUNTER DOCUMENTATION**

I CERTIFY THAT THIS PATIENT IS UNDER MY CARE AND THAT I – OR A NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT WORKING WITH ME – HAD A FACE-TO-FACE ENCOUNTER THAT MEETS THE PHYSICIAN FACE-TO-FACE ENCOUNTER REQUIREMENTS AND THE DIAGNOSIS IS THE PRIMARY REASON FOR HOME CARE SERVICES.

THE ENCOUNTER OCCURRED ON (MONTH / DAY / YEAR) ________________________________

BASED ON THE FINDINGS OF THE ENCOUNTER, I CERTIFY THAT THIS PATIENT IS CONFINED TO THE HOME AND NEEDS INTERMITTENT NURSING AND/OR THERAPY.

**PHYSICIAN NAME** ___________________________  PHONE ( __ __ __ ) __ __ __- __ __ __ __

**PHYSICIAN SIGNATURE** ___________________________  DATE ________________

CONFIDENTIAL: The medical information in this fax message is confidential and protected by both State and Federal Law. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this fax is not the intended recipient or the intended recipient’s agent, you are hereby notified that you have received this fax message in error and that review or further disclosure of this information is strictly prohibited. If you receive this fax in error, please notify us immediately at the telephone number listed above and either destroy these documents or return them to us by mail.
Anemia Management Initial Documentation and Order Form

ST. MARY’S MEDICAL CENTER
3700 WASHINGTON AVENUE
EVANSVILLE, INDIANA 47750
(812) 485-4000

Patient Name: __________________ Date: ___________

Allergies:

Diagnosis: ☐ Anemia in Chronic Kidney Disease PLUS one of the following approved CMS Diagnosis Codes for the
Administration of an ESA in Chronic Kidney Disease not on Dialysis
☐ Chronic Kidney Disease, Stage III (Moderate)
☐ Chronic Kidney Disease, Stage IV (Severe)
☐ Chronic Kidney Disease, Stage V
☐ Another CMS Approved Diagnosis Code

☐ CMS ESRD National Coverage Decision (LCD # L25211) guidelines have been followed for this patient (including but not limited to the following):
- Anemia with Hgb/Hct less than 10 / 30% documented at Initiation of therapy;
- Serum creatinine equal to or greater than 3, creatinine clearance less than 60 mL per minute, or Glomuerular filtration rate (GFR) less than 60 mL per min per 1.73m2


2. ☐ Patient evaluated for other causes of anemia including (but not limited to):
   - Iron Deficiency
   - Folic Acid Deficiency
   - Vitamin Deficiency
   - Occult Bleeding
   - Hemolysis

3. Patient experiencing a significant reduction of activities of daily living (ADLs). Patient demonstrating at least one of the following symptoms specifically related to the Anemia and contributing to a decline in ADL:
   - weakness
   - chest pain
   - shortness of breath
   - ear pain
   - postural hypotension
   - fainting
   - tachycardia
   - marked fatigue

4. Lab History Data from Physician’s Office:

<table>
<thead>
<tr>
<th>Hemoglobin</th>
<th>Date</th>
<th>Lab Value</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute reticulocyte Count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serum Ferritin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serum Iron</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean corpuscular hemoglobin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean corpuscular volume</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean corpuscular hemoglobin concentration</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. The most recent “Office Notes” along with an updated list of the patient’s medications will be faxed along with this Initial Documentation and Order Form to fax # 485-6851.

6. ☐ For patients with End Stage Renal Disease or Chronic Renal Failure check CBC on days that epoetin or darbepoetin is to be given (if not already ordered). Do NOT administer epoetin or darbepoetin until CBC results available. If hemoglobin greater than 11 g per DL (or hematocrit greater than 33%) OR the hemoglobin rises greater than 1 g per DL (or hematocrit rises greater than 3%) over a 2 week period, HOLD the epoetin or darbepoetin dose AND notify the ordering physician or the pharmacist if the patient is being dosed by Pharmacy. If patient does not meet the criteria for ESA administration according to CMS ESRD National Coverage Decision (LCD # L25211), HOLD the epoetin or darbepoetin dose and notify ordering physician or the pharmacist if the patient is being dosed by Pharmacy.

7. Medication Orders:
   - Darbepoetin (Aranesp) __________ mcg subcutaneous __________ Start on __________
   - Epoetinalfa (EpoGen) __________ units subcutaneous __________ Start on __________
   - Iron Sucrose (Venofer) 200 mg IV push over 5 minutes every Monday, Wednesday, and Friday times 5 doses.
   - Iron Sucrose (Venofer) __________ mg IV push over 5 minutes __________ times __________ doses.

Additional Orders:

________________________________________________________________________

Physician Signature __________________ Date/Time __________________

ANEMIA MANAGEMENT INITIAL DOCUMENTATION AND ORDER FORM
7179-282 Page 1 of 1 Rev. 08/07/2014

22
Anemia Management Order

Patient Name: ___________________________ Date of birth: __________________

Allergies: ____________________________

1. Consult Pharmacy for Anemia Management per Protocol.
2. Discontinue all previous Anemia Management orders.
3. See “Anemia Management Initial Documentation and Order Form” for Diagnosis Documentation.
4. Labs—Draw any labs due this visit upon patient’s arrival (UNLESS provided by physician’s office).
   a. Hemoglobin and Hematocrit □ weekly □ every _____ weeks □ every month Beginning _________ (date)
   b. □ Renal Panel □ BMP □ every month □ every _________ Beginning _________ (date)
   c. Iron, total iron-binding capacity, and Ferritin level □ every 3 months □ every _________ Beginning _________ (date)
      — DO NOT draw iron studies on visits where patient is scheduled to receive IV iron.
      — Iron studies should be drawn at next regular scheduled visit after completion of the 5 IV iron dose series.
      — These labs should not be drawn until at least 7 days post completion of the 5 IV iron dose series.
      — If patient is willing to wait for iron study results, contact the pharmacist when results available.
      — Pharmacist will assess the need for IV iron and dose if needed.
      — If patient is unwilling to wait for iron study results, pharmacist will discuss results at next visit and patient may leave without waiting to determine need for IV iron.
   d. □ Vitamin B12 level and folate level (recommended if mean corpuscular volume greater than 100) on ___________ (date)
   e. Other: ____________________________

5. Medications
   a. Darbepoetin (Aranesp) ________ mg subcutaneous every _________, Do not administer until pharmacist has reviewed hemoglobin results.
   b. Epoetin (Procrit) ________ units subcutaneous every _________, Do not administer until pharmacist has reviewed hemoglobin results.
      □ DO NOT administer epoetin or darbepoetin until CBC results available. If hemoglobin greater than 11 g per dl OR the hemoglobin rises greater than 1 g per dl over a 2 week period, HOLD the epoetin or darbepoetin dose AND notify the pharmacist.
   c. Sodium Ferric Gluconate 125 mg IV every ___________ (at a frequency of no less than 24 hours) times ________ doses
      Monitor patient for at least 30 minutes after completion of IV iron administration. (Usual total cumulative dose of 1000 mg IV iron.)
   d. For patients WITH previous sodium ferric infusions:
      Sodium Ferric Gluconate 250 mg IV every ___________ (at a frequency of no less than 24 hours) times ________ doses
      Monitor patient for at least 30 minutes after administration. (Usual total cumulative dose of 1000 mg IV iron.)

6. RN to contact Anemia Management Medical Director for any concerns with patient’s vital signs.
   If Medical Director is unavailable, the patient’s Nephrologist should be contacted.
7. RN to STOP IV IRON and contact pharmacist for any concerns or adverse reactions to IV iron.
   Pharmacist will assess and contact Medical Director for further orders.
   For serious reactions or anaphylaxis, RN to contact Anemia Management Medical Director or patient’s Nephrologist.
8. Anemia Medication Guide:
   a. Give to patient on each Anemia Clinic visit in the Infusion Center.
   b. Document education in patient’s chart.
9. RN to complete and fax an “Anemia Management Communication” form to Nephrology Associates after each Anemia Clinic visit in the Infusion Center.

Physician Signature: ___________________________ Date/Time: __________

ANEMIA MANAGEMENT ORDER
7170-236  Page 1 of 1  Rev. 03/27/2015
Boniva IV Order

Patient Name: ____________________________  Date of birth: ________________

Outpatient Ibandronate (Boniva) IV Orders
Date: __________
Allergies: ______________________________

Indication - Ibandronate (Boniva) should only be used for: (check appropriate boxes)

Primary Diagnosis
☐ Secondary Malignant neoplasm bone marrow
☐ Senile osteoporosis (post menopausal)

Secondary Diagnosis
☐ Severe esophagitis and cannot tolerate oral drugs
☐ Cannot tolerate oral ibandronate sodium

OR

Primary Diagnosis
☐ Hypercaloemia
☐ Other Osteoporosis

Secondary Diagnosis
☐ Severe esophagitis and cannot tolerate oral drugs
☐ Cannot tolerate oral ibandronate sodium

Third Diagnosis
If using "hypercaloemia" or "Other Osteoporosis" a related malignancy code is required along with the Secondary diagnosis.
☐ Malignancy __________________________

☐ Other diagnosis ________________________ may not be covered by insurance

Laboratory:
☐ Serum creatinine prior to each Ibandronate (Boniva) injection. Do Not administer if Creatinine greater than 2.3mg/dl and contact Physician.
☐ Ibandronate (Boniva) 3mg IV, to be given every three (3) months.

______________________________  ____________________________
Physician Signature            Date/Time

Boniva IV Order
7300-186 Page 1 of 1  Rev. 08/07/2014
# Reclast Physician Orders

**Stat**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

**Physician Orders**

- **Patient Name:** [ ]
- **Date of birth:** [ ]

**Allergies:** [ ]

- [ ] Senile Osteoporosis (postmenopausal women/men)
- [ ] Paget’s disease
- [ ] Pathological Fracture of Neck of Femur
- [ ] Other Osteoporosis due to Adrenal Cortical Steroids greater than 12 months
- [ ] Osteopenia
- [ ] Other: [ ]

**Lab Result:**

- Serum Creatinine: [ ]
- Serum Calcium: [ ]

**Date of lab results:** [ ] (Must be within last 30 days)

**Draw labs at appointment time.**

- [ ] YES
- [ ] NO

**The patient has a calculated creatinine clearance of greater than or less than 35 mL per min and a normal serum calcium level.**

- [ ] YES
- [ ] NO

**Patient currently taking calcium and vitamin D supplements.**

- [ ] YES
- [ ] NO

**Prescription:**

Zoledronic acid (Reclast) 5 mg per 100 mL IV infusion over 15 minutes

**Physician Signature**

Date/Time

---

**DO NOT USE:** QD, QOD, U, IU, MS, MSO4, MgSO4

No trailing zero after decimal - Use a zero before a decimal

**Do not write below last line**

---

**Physician Orders**

---

**Reclast Orders**

7200-190 Page 1 of 1 Rev.08/7/2014
# Xolair (omalizumab) Order

**Patient Name:** ________________________________

**Date of Birth:** ________________________________

**Allergies:** ________________________________

1. Is the patient greater than or equal to 12 years of age?  
   - Y  
   - N

2. Does the patient have moderate or severe asthma as defined below?  
   - Moderate Persistent  
     - Daily symptoms of asthma  
     - Asthma exacerbations affecting activity greater than or equal to 2 times a week  
     - Nighttime asthma symptoms more than once a week  
     - Daily use of short-acting beta-agonist  
     - FEV1 and PEF greater than 60% and less than 80% of predicted  
     - PEF variability greater than 30%

   - Severe Persistent  
     - Continuous symptoms of asthma  
     - Frequent asthma exacerbations  
     - Frequent nighttime symptoms (greater than or equal to 5 times per month)  
     - Limited activity due to asthma  
     - Daily use of short-acting beta-agonist  
     - FEV1 and PEF less than or equal to 60% of predicted  
     - PEF variability greater than 30%

3. Has patient had a positive skin test or in vitro reactivity to a perennial aeroallergen?  
   - Y  
   - N

4. Does the patient have a serum IgE greater than or equal to 30 International units/mL? (may be answered as NA)  
   - Serum IgE Concentration: ________________________________  
   - Y  
   - N

5. Does the patient weigh 30-150kg?  
   - Weight: ________________________________  
   - Y  
   - N

6. Is patient symptomatic despite strict compliance with other asthma medications?  
   - Previous/current asthma medications and dispensing location: ________________________________  
   - Y  
   - N

If you answered "N" to any of the questions above, Omalizumab (Xolair) is not indicated for use in this patient. If the patient qualifies, please continue.

7. Omalizumab (Xolair) dose and frequency requested: ________________________________

<table>
<thead>
<tr>
<th>Pre-treatment serum IgE (IU/mL)</th>
<th>Body Weight (kg)</th>
<th>Dosing Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;30-100</td>
<td>30-60</td>
<td>150</td>
</tr>
<tr>
<td>&gt;100-200</td>
<td>&gt;80-70</td>
<td>150</td>
</tr>
<tr>
<td>&gt;200-300</td>
<td>&gt;70-90</td>
<td>150</td>
</tr>
<tr>
<td>&gt;300-400</td>
<td>90-150</td>
<td>300</td>
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<td>&gt;400-500</td>
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<tr>
<td>&gt;500-600</td>
<td>&gt;70-90</td>
<td>225</td>
</tr>
<tr>
<td>&gt;600-700</td>
<td>&gt;90</td>
<td>375</td>
</tr>
<tr>
<td>&gt;700</td>
<td>Do not dose</td>
<td>Do not dose</td>
</tr>
</tbody>
</table>

**Physician Signature**

**Date/Time**
## Medical Nutrition Therapy Dietitian Referral

**PATIENT DATA**

- **Patient Name:**
- **Insurance:**
- **Patient Phone:**
- **Height:**
- **Weight:**
- **DOB:**

**PHYSICIAN DATA**

- **Name:**
- **Address:**
- **UPIN:**
- **Phone:**
- **Fax:**

### Services to be performed:

- [ ] Medical Nutrition Therapy for: ______________________
- [ ] Other service: ______________________

### Number of visits requested:

- [ ] RD to determine

### Diet prescription:

- [ ] RD to determine
- [ ] Physician diet prescription (please specify)
  
  ______________________

### Pertinent Lab Data:

- ______________________

---

Time   Date   ______________________  

Physician Signature

---

The Medical Nutrition Therapy office is located at 3700 Bellemeade Ave. Suite 122 in the Medical Arts Building. Fax: 812-485-7567. **To make an appointment call: 812-485-6020.** Please bring this referral to your appointment.

---

**FOR PATIENT USE:**

MY APPOINTMENT DATE IS: / 
MY APPOINTMENT TIME IS: 
PLEASE CALL (812) 485-6020 AT LEAST 24 HOURS IN ADVANCE IF YOU NEED TO CANCEL THIS APPOINTMENT.
WE WILL RE-SCHEDULE AS SOON AS POSSIBLE.
Thank you for referring your patient to St. Mary’s Pulmonary Care. We appreciate the trust that you have placed in our physicians to provide your patient with the best care possible. We ask that you provide our office with as much information as possible so that our pulmonologists may evaluate and treat your patient in a timely and appropriate manner.

If you like, you can complete the referral process electronically and send our office all the requested documentation, or you may use the attached form to complete the referral. There is no need to complete a paper form if you have submitted the referral request electronically.

Please provide the following information to prevent delays in scheduling:

- Chest X-rays and/or CT
- Hospital Records including Admission/Discharge Summary
- Most recent EKG and/or Echocardiogram
- Recent Labs/Pathology Reports
- H&P and recent office notes for past 6 months
- Current medication list
- Allergy/Immunization list
- Pulmonary function tests/Spirometry/Pulse Ox/6 min walk
- Cardiac testing (stress test, heart catheterization report)

FYI…Scheduling Guidelines for New Pulmonary Nodules:
- <6mm  May schedule up to 8 weeks out
- 6-8mm  Schedule within 6 weeks
- >8mm    Schedule in 2-3 weeks
- >20mm   Schedule Immediately

Thank you again. We will process your referral and notify your office, as well as the patient, of the appointment date and time. If you have further questions, please feel free to call our office at 812.485.6030
Lung Cancer Screening

Initial Lung Cancer Low Dose CT Screening   Circle one: Yes / No

OR

Subsequent Lung Cancer Low Dose CT Screening   Circle one: Yes / No

Ordering Physician or practitioner ________________________________

Signature_______________________________ NPI __________

Patient Information:

First Name_________________________ Middle Name _________ Last Name_________________

DOB____________________ Gender _________________

Indication:   Current Smoker with smoking hx of__________pk/yr

Former Smoker with smoking Hx of__________pk/yr and stopped smoking_________years ago

Patient is without signs or symptoms of lung cancer   Circle one: Yes / No

Schedule an Appointment with Central Scheduling:
812-485-6020, Option 1

Fax completed forms to Central Scheduling:
812-485-756

Lung Cancer Screenings performed at

St. Mary’s Center For Advanced Medicine
901 St. Mary’s Drive
Evansville IN 47714

St. Mary’s Northbrook
3838 N. First Ave
Evansville, IN 47710

St. Mary’s Epworth Crossing
100 St. Mary’s Epworth Crossing
Newburgh, IN 47630
To schedule at any location call (812) 485-6020 option 1

North Pointe (A)
North Pointe Physical Medicine
2330 Lynch Road, Suite 120
Evansville, IN 47711
Fax: (812) 485-6915

Main Campus (B)
St. Mary’s Physical Medicine
3700 Washington Avenue
Evansville, IN 47750
Fax: (812) 485-6850

Washington Square (C)
Washington Square Physical Medicine
1144 Washington Square
Evansville, IN 47715
Fax: (812) 485-5220

Patient Name: ________________________________________________________________

Narrative Diagnosis: ____________________________________________________________

Date of Onset: ____________________________

PHYSICAL THERAPY
❑ Evaluate and Treat
❑ Iontophoresis/Dexamethasone
❑ Modalities
❑ Phonophoresis/Hydrocortisone
❑ Other ______________________

OCCUPATIONAL THERAPY
❑ Evaluate and Treat
❑ Iontophoresis/Dexamethasone
❑ Modalities
❑ Phonophoresis/Hydrocortisone
❑ Splint
❑ Other ______________________

SPEECH THERAPY
❑ Evaluate and Treat
❑ Modified Barium Swallow
❑ Vital Stim/NMES
❑ Videostroboscopy
❑ Laryngectomy

Specific Instructions: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

SPECIALTY PROGRAMS
❑ Aquatic Therapy
❑ Cognitive Rehabilitation
❑ Functional Capacity Evaluation
❑ Fibromyalgia
❑ Hand Injury Rehabilitation
❑ Job-Site Assessment
❑ Lymphedema Management
❑ Vestibular Rehabilitation
❑ Orthopedic/Sports
❑ Strengthening/Conditioning
❑ Therapeutic Concussion Management
❑ Work Hardening/Conditioning
❑ Vision Therapy

Physician Signature: ____________________________ Date: __________________ Time: ________
St. Mary’s Rheumatology Care  
Phone: 812-485-6030  
Fax: 812-485-6091

To provide the best patient experience, these documents are essential to our specialists:  
- Chest X-rays and/or CT; films on disc if not done at St. Mary’s  
- Lab results last 6 months (including most recent RA, ANA with titer, ESR, CRP, other immunology tests, CBC with differential & platelet, Liver panel)  
- H & P and Office Notes/Progress Notes last 6 months  
- Legible Copy of Insurance Card(s)  
- Current Medication List

Date of Referral: ____________________________

Patient Name: ____________________________________________

DOB: ____________________________ SS#: ____________________________

Complete & Current Address: ________________________________

________________________________________________________________________

Home#: ____________________________ Cell#: ____________________________

Insurance: ____________________________________________

Diagnosis/ Reason for Referral: ________________________________

Referring Physician: ________________________________

Referring Office Contact: ________________________________

Referring Office Phone & Fax #’s: ________________________________

**Patient’s Primary Care Provider: ________________________________

You will be contacted by St. Mary’s Rheumatology Care staff with the patient’s appointment date and time. Thank you for allowing us to participate in the care of your patient.
**NOTE: PLEASE SEND H & P OR CONSULT NOTE WITH FORM**

---

**SLEEP DISORDERS CENTER**

**REFERRAL**

Today's Date

Patient Full Name

Patient Date of Birth

Patient Phone (Primary) ($secondary)

Address (City, State, ZIP)

Patient Primary Insurance

Insurance ID#

Insurance Group#

Driver's License Type

Operator

Commercial (CDL)

Public Passenger

---

**PATIENT SYMPTOMS (all applicable)**

- Observed apneas during sleep
- Excessive daytime sleepiness (inappropriate napping, drowsy driving, sleepiness that interferes with daily activities)
- Suspicion of a Parasomnia or sleep disorder other than OSA (Central sleep apnea, narcolepsy, RLS, circadian or shift-work disorders, PLMS)
- Habitual snoring
- Gasping or choking during sleep

---

**DOES THE PATIENT HAVE ANY OF THE FOLLOWING? (all applicable)**

This information allows the specialist to determine which type of study is indicated.

- Chronic Obstructive Pulmonary Disease (COPD)
- Neuromuscular impairment
- Congestive Heart Failure (CHF) Class III or IV
- Cognitive Impairment (e.g. inability to follow simple instructions)
- Insomnia
- Hypertension (HTN)
- BMI >30kg/m² or neck circumference >17 in. male or >16 in. female
- Craniofacial or upper airway tissue abnormalities including enlarged tonsils or neuromuscular disease
- History of stroke > 30 days ago, TIA, CAD, sustained SVT or bradydcardic arrhythmias

---

**REFERRING PHYSICIAN**

Printed Name

Signature

Date/ Time

OFFICE PHONE

FAX

---

***REMEMBER: PLEASE SEND H & P OR CONSULT NOTE WITH REFERRAL FORM***

---

**FOR SLEEP LAB USE ONLY**

SLEEP SPECIALIST PRINTED NAME:

SLEEP SPECIALIST SIGNATURE:

- CONSULT
- IN LAB PSG
- MSLT
- TITRATION
- HOME SLEEP TEST

7135-77 06/13
Patient Name: ________________________________

Diagnosis: ________________________________

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<thead>
<tr>
<th>PT/OT</th>
<th>ST</th>
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<tr>
<td>□ Evaluation</td>
<td>□ Speech/Lang Eval</td>
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<td>□ Evaluate &amp; Rx</td>
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<tr>
<td>□ Gait Training</td>
<td>□ Dysphagia Eval</td>
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<td>□ Back program</td>
<td>□ Dysphagia Eval &amp; Rx</td>
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<tr>
<td>□ Cryotherapy/Ice</td>
<td>□ Oral Motor Rx</td>
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<td>□ Therapeutic Ex</td>
<td>□ Other _____________</td>
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<td>□ Hot packs</td>
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<td>□ Ultrasound</td>
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<td>□ Electrical Stim</td>
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<td>□ US/ES Combo</td>
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<td>□ Iontophoresis</td>
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<td>□ Massage</td>
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<td>□ Cognitive Rx</td>
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Manual Tx  □ ROM  □ TENS  □ Phonophoresis  □ Whirlpool  □ Debridement  □ HEP  □ Vestibular  □ W/C Evaluation  □ Developmental Assessment  □ Other _____________

Frequency: ___________________________________________________________________

Precautions/Contraindications: ___________________________________________________________________

______________________________________________________________________________

THANK YOU FOR YOUR REFERRAL!

Physician's Signature______________________ Date: _________
UROLOGY REQUEST

Phone (812) 473-1111
Fax (812) 485-2461

Doctor Requested:  ____ Bill J. Samm, M.D.  ____ Phillip M. Gilson, M.D.
                ____ Michael K. Zenni, M.D.  ____ Todd D. Renschler, M.D.
                ____ Thomas M. Gadient, M.D.  ____ Michelle A. Boger, M.D.

Check One:  ____ Evaluation & Treatment  ____ Opinion Only

From:
Contact Person: ___________________________ Phone: ___________________________

Referring Physician: ___________________________ Fax: ___________________________

Patient Information:
Patient Name (PRINT): ___________________________
Social Security Number: ___________________________ DOB: ___________________________
Address:
Street: _______________________________________________________________________
City: ___________________________ State: ________ Zip Code: ___________________________
Phone:
Home: ___________________________ Work: ___________________________ Cell: ___________________________

Insurance:
Primary: _______________________________________________________________________
Secondary: _______________________________________________________________________

Procedure and Appointment Information:
Diagnosis: _______________________________________________________________________
Appointment Urgency  ☐ Within one week  ☐ Next Available
Time Preference:  ☐ Mornings  ☐ Afternoons

Appointment Options:
  ☐ Fax appointment time and date to our office. We will contact our patient.
  ☐ We would like for you to contact our patient with the appointment time and date and inform us of the time and date.

Please fax copies of the following:

Labs  X-rays  Progress Notes  Insurance Card(s)

Appointment Date and Time: ___________________________
PHYSICIAN REFERRAL

For Medical Evaluation with Dr. Stephen Braun or Dr. Steven Elliott
For possible: ___ Roux-en-Y Gastric Bypass Surgery    ___ Gastric Sleeve Surgery

Please complete this form and fax to 812-485-5815. If you have any questions, please call 812-485-5858.

Patient Information:

Name: ___________________________ Date of Birth: ____________ Gender: _________
Street Address: _____________________________ Phone: ____________________
City: ___________________________ State: _______________ Zip: __________________

Referring Physician Information:

Name: ____________________________________________________________________________
Office Street Address: _______________________________________________________________
City: ___________________________ State: _______________ Zip: _____________________
Office Phone: _______________ Office Fax: _______________ UPIN: _______________

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<thead>
<tr>
<th>MEDICATIONS</th>
<th>DIAGNOSIS</th>
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I feel this patient is a good candidate for consideration and evaluation for weight loss.

_________________________   ___________________
Physician Signature    Date
To schedule a Women’s Health Physical Therapy Appointment, please fax this prescription to
(812) 485-5724
Or call (812) 485-5725

Patient Name: __________________________ Date: __________________________
Patient Phone: ______________ Patient DOB: ______________ Date of Onset: ______________
Patient Insurance: __________________________

Physician Order: □ Evaluate and Treat □ Evaluate Only □ Other: __________________________

Diagnosis Code: (Bolded items may maximize reimbursement and minimize patient financial responsibility)

Diastasis Recti
Pubic Symphysis Dysfunction
Sacroiliac Joint Pain/Dysfunction
Sacrococcygeal Dysfunction
Thoracic Spine Dysfunction
Painful Coccyx
Low Back Pain
Sciatica
Lumbosacral Strain
Hip Joint Pain
Scoliosis
Costochondritis
Carpal Tunnel
Postural Dysfunction
Peripheral nerve injury, sciatic
Round Ligament Pain
Osteoporosis

Pelvic Floor Dysfunction
Disuse Atrophy
Muscle Weakness
Muscle Pain
Muscle Spasm
Painful Scar/Adherent
Muscular Incoordination

Pelvic Organ Prolapse
Vaginal, Bladder, or Rectal Prolapse without Uterine Prolapse
Uterine Prolapse

Special Instructions/Restrictions

______________________________________________
Physician’s Signature ____________________________ Physician’s Printed Name________________________ Date________________

Associated Pelvic Floor and Pelvic Pain Dysfunction
Dyspareunia (Hypertonus and Pain)
Groin Pain
Levator Ani Muscle Spasm
Perineal Spasm
Myofascial Pain Syndrome
Pelvic Obliquity
Rectal Pain
Pelvic Pain
Vulvodynia
Vaginismus
Interstitial Cystitus
Peripheral nerve injury, pelvis
Mixed Incontinence
Fecal Incontinence
Stress Incontinence
Urgo Incontinence
Overflow Incontinence
Urinary Incontinence without Sensory Awareness
Urinary Frequency
Nocturia
Constipation
Anal Spasm

Other ______________________________

8125.04 Rev. 02/14