

# HOPE INFUSIONS

## Non-Oncology Referral Form



City of  
Hope® | ORANGE  
COUNTY

Hope Infusions Phone Number:

949.671.4146

Hope Infusions Referral Fax:

626.737.1307

### OUR LOCATIONS

Sand Canyon

Newport Beach

Long Beach Elm

Long Beach Worsham

Patient Name \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Allergies No Known Allergies  
Allergic to \_\_\_\_\_

Reaction	Anaphylaxis	Edema	Hives
	Pruritis	Rash	Unknown
	Other _____		

Severity	Severe	Moderate	Mild
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Diagnosis \_\_\_\_\_ ICD-10 code \_\_\_\_\_

Premedication(s) None

Requested Medication(s) \_\_\_\_\_

Repeat every \_\_\_\_\_ (frequency) for a total of \_\_\_\_\_ doses.  
(Note: A new referral form will be required annually for ongoing treatment)

Labs (include frequency) None

For more information and medication options, please visit  
[CityofHope.org/hope-infusions](http://CityofHope.org/hope-infusions)

### Please Fax:

Patient demographics,  
contact and insurance  
information

Pertinent medical records  
and test results

Documentation on previous  
therapies/medications tried  
and failed, if any

Treatment authorization  
information if already  
obtained



Fax completed referral form and patient documents to **626.737.1307**.

**Certification:** As the referring physician, I certify that the patient has been informed of: (a) the risks and benefits of the treatment I am ordering; (b) adverse reactions that may reasonably be expected to occur in connection with the treatment; and (c) alternative options for treatment which are medically viable.

I further certify that the patient has been encouraged to ask questions and that all questions were answered. If applicable, I confirm the patient's pregnancy status is not contraindicated with prescribed treatment and appropriate consultation has occurred. Since I intend to remain primarily responsible for the patient's medical care plan, once the treatment in this referral order is complete, I will provide continuing post-treatment care to the patient.

Printed Name of Physician	Signature/Title	Date (MM/DD/YY)
Office Contact Name		
CA License	Phone	Fax
<b>City of Hope Medical Foundation Non-Oncology Referral Form</b>		<b>This design is approved to go into FormFast Production</b> Form Requestor _____ Form Owner _____



**1 Sand Canyon**  
16300 Sand Canyon Ave., Ste. 207  
Irvine, CA 92618  
PHONE: 949-333-7580  
FAX: 949-333-7599

**2 Newport Beach**  
1601 Avocado Ave.  
Newport Beach, CA 92660  
PHONE: 949-763-2204  
FAX: 949-536-8036

**3 Long Beach Elm**  
1043 Elm Ave., Ste. 104  
Long Beach, CA 90813  
PHONE: 562-590-0345  
FAX: 562-437-8139

**4 Long Beach Worsham**  
3747 Worsham Ave., Ste. 101  
Long Beach, CA 90808  
PHONE: 562-430-5900  
FAX: 562-799-8379

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## Hope Infusions

City of Hope Orange County's expertise in infusion therapy extends beyond cancer-related drugs. We also administer non-oncology medications, all with the same knowledgeable staff and compassionate patient care. Common conditions treated include:

Alzheimer's  
Amyotrophic Lateral Sclerosis (ALS)  
Anemia  
Asthma  
Fabry Disease  
Gout  
Hypercholesterolemia

Hunter Syndrome  
Immunotherapy  
Inflammatory Bowel Disease  
Kidney Transplant  
Lupus  
Migraines  
Multiple Cancers

Multiple Sclerosis  
Osteoporosis  
Polyneuropathy  
Psoriasis  
Rheumatoid Arthritis  
Sarcoid Myocarditis  
Thyroid Eye Disease

**Learn more. Connect with one of our Hope Infusions physician liaisons.**

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[kcarter@coh.org](mailto:kcarter@coh.org)

