

**OP B12 (Weekly) Referral**

Page 1 of 1



Place Patient Label  
Inside This Box

**\*\*\* This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below\*\*\*** Version 6/2021

Date of Infusion: _____	Lead Physician _____
Patient Name: _____	Date of Birth: _____
Patient SSN (if available): _____	Contact Number: _____
Insurance Name: _____	Policy Number: _____
Secondary Insurance: _____	Policy Number: _____
Diagnosis Code: _____	Precertification: <input type="checkbox"/> Initiated <input type="checkbox"/> Complete
Diagnosis Code Description: _____	Location to be Performed:
	<input type="checkbox"/> Moore Regional Hospital (MRH)
	<input type="checkbox"/> Montgomery Memorial Hospital (MMH)
Interval _____ Day _____ of every _____ month	Next Due Date _____
Minimum Separation _____ days / weeks (circle one)	Duration: <input type="checkbox"/> Until discontinued <input type="checkbox"/> _____ Treatments
	<input type="checkbox"/> Until _____

Medications	Interval	Duration
<input type="checkbox"/> cyanocobalamin (VITAMIN B12) injection 1,000 mcg IM weekly	_____	_____

**For Scheduling Fax Forms to: (910) 715-1177.**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

\* May be used as EPIC Downtime Form