Lone Star Infusion

Physician Referral

This form is to be completed by the referring physician.

Patient Name _____ Date of Birth _____

Physician Name _____ Specialty _____

Physician Email _____ Physician Phone _____

I am currently treating this patient for:

_____

_____

_____

This patient and I would like to initiate infusion therapy as an adjunct to the management of this illness.

I acknowledge that I may review information about this therapeutic option at www.lonestarinfusion.com and that I may contact Lone Star Infusion to discuss the treatment.

I will follow up with this patient during and after the completion of the treatment course at Lone Star Infusion or refer him or her to a licensed medical professional for follow-up.

_____ _____

Physician Signature Date

To return the completed form:

Email: mail@lonestarinfusion.com

Fax: 281-719-9393

Mail: Lone Star Infusion
14740 Barryknoll #140
Houston, TX 77079