

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, PLLC to discuss the treatment.

I will follow up with this patient during and after the completion of the treatment course at Lone Star Infusion, PLLC 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
10505 Town and Country Way #79809
Houston, TX 77279