DEHESA DERMATOLOGY
DERMATOLOGY-RHEUMATOLOGY-PLASTIC SURGERY-INFUSION CENTER-RESEARCH

Phone: 559.951.9000 | Fax: 559.234.6334
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INFUSION REFERRAL FORM

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____

Patient Name: _____DOB: _____

Patient Home Phone: _____ Patient Cell: _____

Diagnosis (required):

_____

REQUESTED INFUSION/INJECTIONS

All infusion orders can be found online: https://dehesadermatology.com/online-forms/

☐ Prolia (Denosumab
☐ Abatacept (Orencia)
☐ Anifrolumab (Saphnelo)
☐ Benlysta (Belimumab)
☐ Cimzia (Certolizumab)
☐ Entyvio (Vedolizumab)
☐ Skyrizi (Risankizumab)
☐ Boniva (Ibandronate)
☐ Reclast (Zoledronic Acid)

☐ Remicade (Infliximab)
☐Rituxan (rituximab)
☐Cytoxan (Cyclophosphamide)
☐Krystexxa (Pegloticase)
☐ IVIg
☐ Inflectra (infliximab-dyyb)
☐ Actemra (tocilizumab)
☐ Gazyva (Omalizumab)

☐ Simponi Aria (Golimumab-IV)
☐ Stelara (Ustekinumab)
☐ Ilumya (Tildrakizumab)
☐ Iron Infusion (Specify):
_____
☐ IV Fluids (Cash Pay)
☐ Other:
_____

REQUIRED PATIENT INFORMATION

□ Copy of patient insurance card
□ Copy of patient demographics
□ Copy of last chart notes

Special Instructions: _____

_____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

Appointment Date: _____ Time: _____ Contact Person: _____

Thank you for referring your patient to our office.

Updated:5.26.26