

## REFERRAL FORM

<b>PATIENT/PRESCRIBER</b>	<b>PATIENT INFORMATION</b>		<b>PRESCRIBER INFORMATION</b>	
	First name:	MI:	Title:	First name:
	Last name:		Last name:	State license #:
	Patient DOB:	Sex:	Provider NPI #:	DEA #:
	Address:		Office name:	Office contact:
	City/State/Zip:		Address:	
	Primary phone:		City/State/Zip:	
	Alternate phone:		Phone:	Fax:

<b>INSURE</b>	<b>FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARD(s)</b>			
	Primary insurance:	Policy ID #:	Group #:	
	Policyholder name:	Policyholder DOB:	PCN:	BIN:

<b>CLINICAL</b>	Primary diagnosis:	Height:	Weight:
	ICD 9:	Allergies:	
	Other health conditions:	Current medications:	

<b>PRESCRIPTION INFORMATION</b>	Date needed:	<input type="checkbox"/> New prescription	<input type="checkbox"/> Refill prescription	<input type="checkbox"/> New to therapy	<input type="checkbox"/> Restarting therapy
	Delivered to:	<input type="checkbox"/> Patient's home	<input type="checkbox"/> Prescriber's facility	<input type="checkbox"/> Other: _____	
	<b>Medication Form / Strength / Dose / Directions / Frequency / Quantity</b>				
<input type="checkbox"/> Check here if you would like the associated supplies dispensed along with injectable medications. State restrictions apply. Separate prescriptions are required in some jurisdictions.					
<b>REFILLS: NR 1 2 3 4 5 _____</b>					

**PRESCRIBER SIGNATURE:** PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

**Dispense as written/Do not substitute** \_\_\_\_\_ **Date**       **Substitution permitted/Brand exchange permitted** \_\_\_\_\_ **Date**

For states requiring hand-written expressions of product selection use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).