

Date Shipment Needed: _____ Ship To: Patient Prescriber
 Nursing needed; Training needed ► All the supplies including syringes and needles will be dispensed if needed.

GENERAL REFERRAL FORM

PATIENT INFORMATION					
Patient Name: _____		DOB: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: _____	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN: _____	Phone: _____	Allergies: _____			
Address: _____		City: _____	State: _____	Zip: _____	
Emergency Contact: _____		Phone: _____	<input type="checkbox"/> Please attach demographic information		
PRESCRIBER INFORMATION					
Prescriber: _____		NPI: _____	DEA: _____	State Lic: _____	
Supervising Physician: _____		Practice Name: _____			
Address: _____		City: _____	State: _____	Zip: _____	
Phone: _____	Fax: _____	Key Office Contact: _____		Phone: _____	
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT					
Primary Diagnosis: (ICD-10 Code & Description) _____					
<input type="checkbox"/> Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____					
<input type="checkbox"/> Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____					
<input type="checkbox"/> Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____					
<input type="checkbox"/> How long should patient wait before starting the new medication? _____					
<input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
COPAY CARD ENROLLMENT					
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____			
PRESCRIPTION INFORMATION					
<input type="checkbox"/> Medication: _____		<input type="checkbox"/> Dose: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Sig: _____					
<input type="checkbox"/> Medication: _____		<input type="checkbox"/> Dose: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Sig: _____					
<input type="checkbox"/> Medication: _____		<input type="checkbox"/> Dose: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Sig: _____					
<input type="checkbox"/> Medication: _____		<input type="checkbox"/> Dose: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Sig: _____					
<input type="checkbox"/> Medication: _____		<input type="checkbox"/> Dose: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Sig: _____					
<input type="checkbox"/> Medication: _____		<input type="checkbox"/> Dose: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Sig: _____					
<input type="checkbox"/> Medication: _____		<input type="checkbox"/> Dose: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Sig: _____					

Prescriber's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

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