

# PATIENT REFERRAL/PATIENT REQUEST FORM

(electronically transmitted prescription)

Prescriber: \_\_\_\_\_ DEA# \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
( ) \_\_\_\_\_ (ph) ( ) \_\_\_\_\_ (fax) Date: \_\_\_\_\_

**REQUIRED!** Date Need by: \_\_\_\_\_ Deliver to:  Patient  MD Office  Other: \_\_\_\_\_

**PATIENT INFO.** Attach copy of patient's demographic sheet or complete.

Patient Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

**INSURANCE INFO** Attach copy of patient's insurance card (both sides), insurance info. from medical record or complete.

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_  
Policy # \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_ Group # \_\_\_\_\_  
Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

**MEDICATION INFO**

ICD-9 Diagnosis Code \_\_\_\_\_ Weight \_\_\_\_\_ Allergies \_\_\_\_\_  
Is patient currently on therapy? Y / N \_\_\_\_\_ Date of next blood work ? \_\_\_\_\_

**PRESCRIPTIONS**

**Xeloda** **Quantity** \_\_\_\_\_ days supply  
Sig:  Take \_\_\_\_\_ 150mg and \_\_\_\_\_ 500mg tabs every AM and PM\*  
pc x 2 weeks, stop x 1 week, then repeat.  
\* (See recommended dosing per pkg. insert on reverse)  
 Other \_\_\_\_\_ Refills X \_\_\_\_\_

**Thalidomide (Thalomid)** **Quantity** \_\_\_\_\_ days supply  
Sig:  Take \_\_\_\_\_ 50mg capsules and \_\_\_\_\_ 100mg capsules and  
\_\_\_\_\_ 200mg capsules daily.  
 Other \_\_\_\_\_ Refills X \_\_\_\_\_

	Vial Strength	Quantity
<b>Blood Stimulating Factors</b>		
<b>Procrit</b> <input type="checkbox"/> 1ml SC 3 x per week <input type="checkbox"/> 1ml SC _____ x per week	<input type="checkbox"/> 10,000u/1ml Single Dose Vials <input type="checkbox"/> 20,000u/1ml Single Dose Vials <input type="checkbox"/> 40,000u/1ml Single Dose Vials	_____ days supply Refills X _____
<b>Aranesp</b> <input type="checkbox"/> Inject _____ mcg SC one (1) x per week <input type="checkbox"/> Other _____	<input type="checkbox"/> 25mcg/1ml Single Dose Vials <input type="checkbox"/> 40mcg/1ml Single Dose Vials <input type="checkbox"/> 60mcg/1ml Single Dose Vials <input type="checkbox"/> 100mcg/1ml Single Dose Vials <input type="checkbox"/> 200mcg/1ml Single Dose Vials	_____ days supply Refills X _____
<b>Neupogen</b> <input type="checkbox"/> Inject _____ ml SC daily starting on _____ (Date) <input type="checkbox"/> Other _____	<input type="checkbox"/> 300mcg/1ml Single Dose Vials <input type="checkbox"/> 480mcg/1ml Single Dose Vials	_____ days supply Refills X _____
<b>Neulasta</b> <input type="checkbox"/> Inject 0.6ml (6mg) SC 1 x per treatment cycle on _____ (Date) <input type="checkbox"/> Other _____	<input type="checkbox"/> 6mg/0.6ml Syringe	_____ days supply Refills X _____

**Additional Meds**  
Item: \_\_\_\_\_ SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills: \_\_\_\_\_  
Item: \_\_\_\_\_ SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills: \_\_\_\_\_

Physician Signature \_\_\_\_\_

# FAX COVER SHEET



315 Pleasant Street  
Building 1, 6th floor  
Fall River, MA 02721  
800-218-5688 (phone)

**800-830-5292 (fax)**

**ATTENTION: Please remember to include the Need by Date and delivery location to help us deliver your patient's order on time.**

**Date:** \_\_\_\_\_

**Senders Name:** \_\_\_\_\_

**Direct Phone #:** \_\_\_\_\_

**My fax # is:** \_\_\_\_\_

We are transmitting a total of \_\_\_\_\_ pages, including this cover page.

**Additional Notes:**