PATIENT REFERRAL FORM

(electronically transmitted prescription)

Prescriber:______________________________ DEA #:____________________________

Address:____

City:_____________________________ State:_______________ Zip:_______________

(   )______-_____________________(PH) (   ) ______-______________________ (FAX) Date:______________

REQUIRED! **Need by: Date________________** **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 # _______________________________________

MEDICALHISTORY/INFO

ICD-9 Codes ☐ 714.0 Rheumatoid Arthritis ☐ 715.9 Osteoarthritis ☐ ______________________________

PRESCRIPTIONS

Enbrel 25mg/1ml Syringe ☐
50mg/1ml Syringe ☐

SIG: ☐ (adults) Inject 25mg (1ml) SC 2 times per week@ 72 to 96 hours apart
☐ (4 - 17 y/o) Inject 0.4mg/kg x ____ kg SC 2 times per week @ 72 to 96 hrs apart (up to 25mg/dose)
☐ Inject 50mg (1ml) SC Once Weekly ☐ ____

Quantity
___________ Weeks
(Each box is a 4-week supply)
REFILLS X _________

Humira 40mg/0.8ml Syringe

SIG: ☐ Inject 40mg (0.8ml) SC every 2 weeks or as directed
☐ Inject _______ mg SC every 2 weeks or as directed
☐ ________________________________

Quantity
___________ Weeks
(Each box is a 4-week supply)
REFILLS X _________

Kineret 100mg/0.67ml Prefilled Syringe

SIG: ☐ inject 100mg (0.67ml) SC once daily
☐ ____

Quantity
#___________ Boxes
(Each box is a 4-week supply)
REFILLS X ________

Hyalgan 20mg/2ml Syringe

SIG: ☐ MD to inject 20mg (2ml) in ☐ L ☐ R ☐ Both knees once weekly x 5 weeks
☐ ____

Quantity
#___________ Syringes
(Each is a 1 week supply/knee)
REFILLS X _________

Orthovisc 30mg/2ml Syringe

SIG: ☐ MD to inject 25mg (2.5ml) in ☐ L ☐ R ☐ Both knees once weekly x 3-4 weeks
☐ ____

Quantity
#___________ Syringes
(Each is a 1 week supply/knee)
REFILLS X ________

Synvisc 16mg/2ml Syringe

SIG: ☐ MD to inject 16mg (2ml) in ☐ L ☐ R ☐ Both knees once weekly x 3 weeks
☐ ____

Quantity
#___________ Boxes
(Each is a 4 week supply/knee)
REFILLS X ________

Supplies/Additional Meds

	Item		Quantity	
Supplies:	☐ 18g 1.5" Needle	(Synvisc)	# ____________	REFILLS X________
	☐ 20g 1.5" Needle	(Synvisc, Hyalgan)	# ____________	REFILLS X________
	☐ 22g 1.5" Needle	(Synvisc)	# ____________	REFILLS X________
Additional Meds:	______________________________		# ____________	REFILLS X________

Physician Signature ______________________________________

Interchange is mandated unless the practitioner writes the words "no substitution" in the above space

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: