

# PATIENT REFERRAL/MEDICATION 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.** Please complete or attach copy of patient's insurance card (both sides) or profile information

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/Drug Card # \_\_\_\_\_ Policy/Drug Card # \_\_\_\_\_  
Group # \_\_\_\_\_ Group # \_\_\_\_\_  
Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

**MEDICATION INFO.**

Weight \_\_\_\_\_ Allergies \_\_\_\_\_

## PRESCRIPTIONS

Prescription #1

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescription #2

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescription #3

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescription #4

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescription #5

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescription #6

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescription #7

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescription #8

\_\_\_\_\_ quantity \_\_\_\_\_ refills  
Drug and Strength directions for use

Prescriber 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:**