

Date Shipment Needed: _____ Ship To: Patient Physician; 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 | | |
| INSURANCE INFORMATION | | | | | |
| <input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription) | | | | | |
| PRESCRIBER INFORMATION | | | | | |
| Prescriber: | | NPI: | DEA: | State Lic: | |
| Supervising Physician: | | Practice Name: | | | |
| Address: | | City: | State: | Zip: | |
| Phone: | Fax: | Key Office Contact: | | Phone: | |
| DIAGNOSIS INFORMATION / MEDICAL ASSESMENT | | | | | |
| 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): _____ _____ | | | | | |
| PRESCRIPTION INFORMATION | | | | | |
| <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ | | | | | |
| <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ | | | | | |
| <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ | | | | | |
| <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ | | | | | |
| <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ | | | | | |

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

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription 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.