

Need a referral status update, Please provide your email:

***Patient Insurance & ID (front and back) are needed**

- ☐ New Prescription/Referral
☐ Prescription Refill

PRESCRIPTION(Rx)/REFERRAL

Rx:	Patient Name:	Patient Weight:	DOB:
		kg	
MEDICATION/Strength:		ROUTE: ☐ Peripheral IV ☐ Port	
		☐ PICC ☐ SubQ	
Directions:		☐ Midline ☐ IM	

DIAGNOSIS:	ICD-10 CODE:

Pre-Medication:	☐ Benadryl _____mg	ANA Kit Protocol:
☐ Solumedrol 125mg IVP	☐ Tylenol _____mg PO	☐ OK to use
☐ Solu-Cortef _____mg IVP	☐ 650mg ☐ 975mg	
	☐ 25mg ☐ IV	
	☐ 50mg ☐ PO	

Physician Signature	Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:	CLINIC:

Contact Information:		
Phone:	Other:	Email:

Office Mailing Address:

Check that the following are included:		
☐ Patient demographics & Insurance attached	☐ Lab Results	☐ Medication List
☐ Clinical progress notes	☐ Other Test Results	
☐ History and Physical	☐ Diagnosis (supporting)	