AcariaHealth™
An envolve Pharmacy Solution
Phone: 800.511.5144 ● Fax: 877.541.1503

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: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

INSURANCE INFORMATION

❑ **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) _____

- Has patient been treated *previously* for this condition? ❑Yes ❑ No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑ No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑ Yes ❑ No If yes:
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

PRESCRIPTION INFORMATION

❑**Medication:** _____ Sig: _____ QTY: _____ Refills: _____

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❑**Medication:** _____ Sig: _____ QTY: _____ Refills: _____

❑**Medication:** _____ Sig: _____ QTY: _____ Refills: _____

❑**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.