NEPHROLOGY REFERRAL FORM

Phone:
Fax:
Toll Free:

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed: _____

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City/County: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
DOB: _____ Caregiver: _____
Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (BOTH FRONT & BACK)
IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY: _____

Medication Information

Injectable Medication	Available Strengths	SIG/Directions	Quantity	Refills
☐ Copaxone	_____ mcg Syringe _____ mcg Vial			
☐ Procrit	units/mL Supplies: Syringes _____ mL Needles _____ G, in"			

Injectable Medication	Available Strengths	SIG/Directions	Quantity	Refills
☐ Fosrenol	☐ 500mg ☐ 750mg ☐ 1000mg			
☐ PhosLo (calcium acetate)	☐ 667mg			
☐ Renvela	☐ 800mg			
☐ Zemplar	☐ 1mcg ☐ 2mcg ☐ 4mcg			
☐ Hectorol	☐ 0.5mcg ☐ 1.0mcg ☐ 2.5mcg			
☐ Rocaltrol (calcitriol)	☐ 0.25mg ☐ 0.5mg			
☐ Sensipar	☐ 30mg ☐ 60mg ☐ 90mg			

Laboratory Values

Weight: _____ Height: _____ ICD-9 Code: _____
Allergies: _____

☐ Hgb Date: _____ ☐ TIBC Date: _____
☐ Hct Date: _____ ☐ Tsat Date: _____
☐ Ferritin Date: _____ ☐ Ca Date: _____
☐ Iron Date: _____ ☐ PO4 Date: _____

Prescriber Information

Facility Name: _____
Facility Contact: _____ Phone #: _____ Fax #: _____
Address: _____ City/County: _____ State: _____ Zip: _____
DEA #: _____ NPI #: _____ Medicaid #: _____
Email Address: _____ Best way to contact: ☐ Phone ☐ Fax ☐ Email

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name: _____
Prescriber's Signature: _____ Date: _____

No Stamps. Prescriber signature required