University Specialty Pharmacy
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Oncology "Injectables" Referral Form

Patient Name: (First) _____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____ SS#: _____

Date of Birth: _____ Patient's Height: _____ Patient's Weight: _____ Male ☐ Female ☐

Parent/Guardian if child: _____ Address: _____

Primary Insurance: _____ Phone: ( ) _____ **PLEASE ATTACH COPY OF CARD!**

Cardholder Name: _____ ID# _____ Group# _____ Employer: _____

Patient Drug Allergies: _____

CLINICAL INFORMATION ☐ Diagnosis: _____ Date of Diagnosis _____

Has patient been previously treated for this condition? ☐ Yes ☐ No Medications: _____

Is patient currently on other therapy? ☐ Yes ☐ No List other medications and dosage, including OTC: _____

_____

PRESCRIPTION

☐ **Neupogen®**
☐ **Neulasta®**
☐ **Procrit®**
☐ **Aranesp®**
☐ **Neumega®**
☐ **Other** _____

SIG: Inject Dose: _____mg ☐ SQ ☐ IM Frequency: _____

Dispense Quantity: _____ Refills: _____

Other Instructions: _____

Deliver Product to: ☐ Office ☐ Patient's Home ☐ Other: _____

_____ _____
Physician's Signature **Date**

Physician Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____ **Fax:** _____

DEA #: _____ **License #:** _____ **NPI#:** _____ **State:** _____

Office Contact: _____ **Email:** _____

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