GENERAL REFERRAL FORM

vitalcare of SOUTH DALLAS

☐ Home Infusion ☐ Alternate Site of Care

NPI #: 1871219683 **TEL:** 945-212-3707 **FAX:**866-790-3580

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at: ☐ Home ☐ Work ☐ Other _____ Local Pharmacy Phone _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

Practice Name _____ Primary Contact_____ Tel_____
Prescriber _____ NPI #_____ License #_____
Practice Address _____ Suite# _____ City _____ State _____ Zip _____
Email Address _____ Fax_____

**** Please fax a copy of front and back of insurance card ****

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____ ID#_____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis:_____ Diagnosis: _____
Testing? ☐ Yes ☐ No Results: _____
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work_____

PRESCRIPTION

PLEASE ATTACH CLEAR COPIES OF BOTH SIDES OF PATIENT'S INSURANCE CARDS

****NOT FOR CONTROLLED SUBSTANCES****

☐ **MEDICATION #1:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #2:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #3:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #4:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #5:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #6:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

☐ **MEDICATION #7:** _____
Strength/Dosage: _____
SIG: _____ QTY: _____ Refills _____

By signing this form and utilizing our services, you are authorizing VitalCare of South Dallas, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____

Prescriber's Email_____