

GENERAL REFERRAL FORM



☐ 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 _____

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to VitalCare of South Dallas or any of its subsidiaries using the contact information provided on this cover sheet.

Please visit VITALCARE.COM/LOCATIONS/VITAL-CARE-OF-SOUTH-DALLAS/ for more information

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