# SPECIALTY PHARMACY REFERRAL FORM

## PATIENT INFORMATION

Patient Name: ______________________ DOB: __________

Address: ______________________

City: __________ State: __________ ZIP: __________

Home Phone: __________ Work Phone: __________

Allergies: ______________________

Is patient pregnant? ☐ Yes ☐ No Patient's Height: __________ Patient's Weight: __________

## INSURANCE INFORMATION

Please provide the following information, or attach a photocopy of insurance card, if available.

Provide Insurance: __________ Phone: __________

Employer Group Name: __________ Group #: __________

ID #: __________ Subscriber's Name: __________

Secondary Insurance: __________ Phone: __________

Employer Group Name: __________ Group #: __________

ID #: __________ Subscriber's Name: __________

## DIAGNOSIS INFORMATION (please specify primary and secondary diagnosis)

Primary Diagnosis: __________ ICD-10 Code: __________

Secondary Diagnosis: __________ ICD-10 Code: __________

## PATIENT MEDICATION HISTORY (NOT including Current Drug Order)

______________________

______________________

______________________

## PRESCRIPTION INFORMATION

Order: ______________________

Dosage/Duration: ______________________

☒ Provide Ancillary Supplies as needed

Follow Oso Protocol for Anaphylaxis and Infusion Reactions

## NURSING

☐ Oso to coordinate nursing services ☐ MD's office will coordinate nursing ☐ Nursing will NOT be required

## DELIVERY INSTRUCTIONS

☐ Patient's Home ☐ Infusion Suite ☐ Physician's Office ☐ Other: __________

## PHYSICIAN INFORMATION

MD Name: __________ Office Contact: __________

Address: ______________________

Phone: __________ Fax: __________

License #: __________ DEA#: __________ Medicade#: __________

MD Signature: __________ Date: __________

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