Dermatology Referral Form





Fax completed form to: 833-908-1122

DATIENT INFORMATION							
		PATIENT	T INFORMATION				
Patient Name:		Date of Birth:			Referral Date:		
Address:		City/State/Zip:					
Home Phone:		Cell Phone:			Work Phone:		
Secondary Contact:		Height: Weight:			Male Female		
Patient Diagnosis & ICD	D-10:						
Allergies:							
PROVIDER INFORMATION							
Physician Name:		Lic.#:		DEA #:			
Practice Name:		NPI#:					
Address:		City/State/Zip:					
Office Contact:		Phone: Fax:					
Supervisory Physician (if applicable):							
PLEASE ATTACH							
Patient demograph	Patient demographics & front/back copy of all insurance cards (prescription & medical) TB lab results within last 12 months (Stelara, Simponi Aria, Ilumya & Infliximabs only)						
	otes, history & physical, lab & pertinent procedu	•			nfliximabs & Simponi Aria only)	-	
	list & list of prior medications tried and failed (w				g or indication is outside of FDA guidelines		
	,		G & LAB ORDERS		<u>,</u>		
Nurse Orders: Nurse to	o provide assessment, teaching, lab draws, medi	ication administration an	d vascular access device insert	ion and/or mai	nagement per physician orders.		
	% - 5-10mL flush pre and post infusion and as n				flush after post-infusion NS flush if indicate	d to maintain line	
Lab Orders: Lab Orders:							
PRESCRIPTION ORDERS							
Anaphylaxis Kit: Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV as needed Solu-Medrol 60mg - 125mg IV as needed							
(Check all that apply)	Diphenhydramine mg IV as		ation 500 ml IV over 30 minute		Other	5	
Pre-Medications:	Acetaminophenmg PO	minutes prior to					
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary							
	<u>Diphenhydramine</u> mg oplies for vascular access line care, drug administ				Other		
		tration kit(s), pump, and I		essary	Other	REFILLS	
Supply Orders: All sup PRODUCT	pplies for vascular access line care, drug administ	tration kit(s), pump, and l PRESCRIPT	V pole will be provided as neco	essary ION	Other	REFILLS	
Supply Orders: All sup PRODUCT	plies for vascular access line care, drug administ	tration kit(s), pump, and l PRESCRIPT	V pole will be provided as nec	essary ION	Other	REFILLS	
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Prescriber's Signature

<u>Dispense as Written</u>

Print Name Date

Prescriber's Signature
Substitution Permitted

Print Name

Date





