ST.JUDE SPECIALTY PHARMACY & MEDICAL SUPPLIES

UROLOGY ANTI-INFECTIVE PRESCRIPTION REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Date: _____

☐ NEW PATIENT
☐ CURRENT PATIENT

URAC ACCREDITED Specialty Pharmacy

Patient Name First Name Middle Name Last Name DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

ICD-10 Code _____ Diagnosis _____ Allergies _____

Diabetic ☐ Yes ☐ No Results _____ Insulin Dependent ☐ Yes ☐ No Date of next blood work _____

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# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

	Anti-Infective Therapy 1		Anti-Infective Therapy 2	
Therapy Ordered	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Ertapenem ☐ Ceftolozane / tazobactam ☐ Other:	Dose: _____ Frequency: _____ Start Date: _____ Duration: _____	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Ertapenem ☐ Ceftolozane / tazobactam ☐ Other:	Dose: _____ Frequency: _____ Start Date: _____ Duration: _____
Services Ordered	☐ Pharmacy only ☐ Home Health ☐ Nursing/HHA Name:	Is patient Homebound? ☐ Yes ☐ No		
Flushing	☐ NS 5 ml SASH and prn ☐ Heparin 20 units ☐ Heparin 100 units SASH and prn	Access: None ☐ or Type: _____ Date inserted: _____		

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____