844-243-7833 Phone
949-864-2320 Fax
QUESTIONS? Please contact us!
Info@.ClinIVoy.com

Patient Referral Form

Send your referral to: ______________________

Date Medication Needed: __________

1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: ______________ Birthdate: __________ Sex: ( ) Male ( ) Female Height: ______ Weight: ______ ( ) lbs. ( ) kg.
Soc. Sec. #: __________ Preferred Phone: __________ Known Allergies: ______________
Address: ______________ City: __________ State: ______ Zip: ______
Alternate Caregiver Name: ______________ Preferred Phone: ______________

2. Referring Physician Information

Referral Name: __________ Specialty: __________
Address: ______________ Phone: __________ Fax: __________
City, State, Zip: ______________ Key Contact: __________ Phone: __________

3. Diagnosis/Clinical Information

Please include recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Body Weight: ____ lb/Kg Age: ______ Adult/Pediatric: ______________

Diagnosis:
- ☐ ICD-10
- ☐ ICD-10
- ☐ ICD-10
- ☐ ICD-10

Lab Work:
- ☐
- ☐
- ☐
- ☐ ______________
- ☐
- ☐

History / Current Medical Status:

____

____

Tried and Failed Medication:

____

____

4. Prescription Information

Drug Name	Strenght	Dose / Frequency / Route	Refill

5. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature ______________ **Date** __________

6. Referring Physician Signature

Prescriber, please sign and date below

Referring Signature ______________ **Date** __________ **Substitution Permissible** ______________ **Date** __________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**