



844-243-7833 Phone  
 844-893-7279 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	Strength	Dose / Frequency / Route	Refill

### 5. Patient Support Programs Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

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.