CureStat Rx
Home Infusion and Specialty Pharmacy

STANDARD
REFERRAL FORM

6725 MESA RIDGE RD. STE 230. SAN DIEGO, CA 92121
PHONE: (888) 963-6544 FAX: (858) 281-0045

PATIENT INFORMATION

PATIENT NAME:		PRIMARY PHONE:	
DOB:		ADDRESS:	
SSN:		CITY, STATE, ZIP:	
CAREGIVER NAME:		ALTERNATE PHONE:	

INSURANCE INFORMATION

(PLEASE FAX A COPY OF PATIENTS INSURANCE CARD INCLUDING BOTH SIDES)

PRIMARY INS:		SECONDARY INS:	
PLAN ID:		PLAN ID:	

PRIMARY DIAGNOSIS:

(PLEASE PROVIDE ICD-10 CODE)

☐ ☐

CLINICAL INFORMATION

GENDER: ☐ M ☐ F
WEIGHT: ☐ lbs ☐ kg
HEIGHT: ☐ In ☐ cm
TB/PPD TEST: ☐ Yes ☐ No

DIAGNOSIS DATE:	
COMORBIDITIES:	
CONCOMITANT MEDICATIONS:	
ALLERGIES: ☐ NKDA ☐ OTHER	
ADDITIONAL COMMENTS:	

PRIOR THERAPY

(PLEASE PROVIDE MEDICATION HISTORY)

PRIOR THERAPY ☐ YES ☐ NO	REASON FOR DISCONTINUATION OF THERAPY	START DATE	END DATE

REQUIRED DOCUMENTATION:

☑ INSURANCE CARD FRONT AND BACK ☑ MOST RECENT LABS ☑ H & P

DRUG	DOSE / STRENGTH	DIRECTIONS	QTY	REFILLS

INJECTION TRAINING PROVIDED BY: ☐ PRESCRIBER'S OFFICE ☐ PHARMACY ☐ N/A

SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER:

☐ PRODUCT SUBSTITUTION PERMITTED ☐ DISPENSE AS WRITTEN NEEDS BY DATE:

PRESCRIBER INFORMATION

PHYSICIAN NAME:		**PHONE:**	
OFFICE CONTACT:		**FAX:**	
ADDRESS:		**LICENSE #:**	
CITY:		**NPI #:**	
STATE, ZIP:		**DEA #:**	

PRESCRIBER'S SIGNATURE:		**DATE:**	