CureStat Rx
Home Infusion and Specialty Pharmacy

UROLOGY
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)

☐ OTHER: ☐ OTHER:

CLINICAL INFORMATION

GENDER: ☐ M ☐ F		DIAGNOSIS DATE:	
WEIGHT: ☐ lbs ☐ kg		COMORBIDITIES:	
HEIGHT: ☐ In ☐ cm		CONCOMITANT MEDICATIONS:	
		ALLERGIES: ☐ NKDA ☐ OTHER	

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
☐ **FOSFOMYCIN**				
☐ **GENTAMICIN (BLADER IRRIGATION)**				
☐ **HcG**				
☐ **LUPRON**				
☐ **MYRBETRIC**				
☐ **TESTOSTERONE**				
☐ **Tice BCG**				
OTHER				
☐				

SHIP TO: ☐ PATIENT ☐ PRESCRIBER'S OFFICE NEEDS BY:

INJECTION TRAINING PROVIDED BY: ☐ PRESCRIBER'S OFFICE ☐ PHARMACY ☐ NA

PRODUCT SUBSTITUION PERMITED: ☐

DISPENSE AS WRITTEN: ☐

PRESCRIBER INFORMATION

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

PRESCRIBER'S SIGNATURE:		**DATE:**	

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