PODIATRY REFERRAL FORM

Jersey Shore Pharmacy

580 N. Main Street • Barnegat, NJ 08005
Phone: 609-660-1111 • Fax: 609-660-0101

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name _____ Date of Birth _____
☐ Male ☐ Female SS# _____ Language _____
Address _____ Apt # _____
City _____ State _____ ZIP _____
Phone _____ Cell _____ Email _____
Allergies _____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

Insured's Name _____
Relation to Patient _____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Phone _____ Fax _____
Policy/Group# _____
Bin# _____ Pcn# _____
RXID# _____ RX Group# _____

ICD-10 Code _____ Diagnosis _____
Testing? ☐ Yes ☐ No Results: _____
Is the patient currently on therapy? ☐ Yes ☐ No Date of next blood work: _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

ANTIFUNGAL
☐ Ala-Quin Cream
☐ Ciclodan Cream
☐ Clotrimazole 1% Cream
☐ Econazole 1% cream
☐ Ecoza ____% Foam
☐ Kerydin Solution
☐ Luzu Cream
☐ MetroGel
☐ Miconazole 2% Cream
☐ Naftin Cream
☐ Nystatin Powder
☐ Nystatin 100M Cream
☐ Terbinafine 1% Cream
☐ Tolnaftate 1% Cream
☐ Tolnaftate 1% powder
☐ Xolegel Gel
Sig: _____ QTY: _____ Refill: _____

FOOT WOUNDS & PAIN
☐ Alevicyn Gel
☐ Alevicyn SG
☐ Alevicyn Spray
☐ Dakin's Solution
☐ Domeboro Packets
☐ Intrasite Gel
☐ Iodosorb Gel
☐ Pennsaid 2% Solution
☐ Recedo Gel
☐ Solaraze 3% Gel
☐ Voltaren 2% Gel
Sig: _____ QTY: _____ Refill: _____

KERATOSIS & WARTS
☐ Carac 0.5% Cream
☐ Fluoroplex 1% Cream
☐ Imiquimod 5% Cream
☐ Picato 0.015% Gel
☐ Salicylic Acid ____% Soln
☐ Zyclara 2.5% Cream
☐ Zyclara 3.75% Cream
Sig: _____ QTY: _____ Refill: _____

RASHES & ECZEMA
☐ Clobex Spray
☐ Cordran Cream
☐ Cordran Lotion
☐ Cordran Ointment
☐ DrySol Solution
☐ Dermasorb AF / HC / TA
☐ EpiCeram Emulsion
☐ Hydro 35 Foam
☐ Kenalog Spray
☐ Nivatopic Plus Cream
☐ Trianex 0.05% Ointment
☐ Topicort Spray
☐ Topicort Cream
☐ Vanos Cream
Sig: _____ QTY: _____ Refill: _____

NAIL SOLUTIONS
☐ Ciclodan Solution
☐ Genadur Nail Kit
☐ Jublia Solution
☐ Nuvail Nail Solution
☐ Umecta 40% Nail Solution
☐ Uramaxin 45% Nail Gel
Sig: _____ QTY: _____ Refill: _____

☐ OTHER: _____ Dosage: _____
Sig: _____
QTY: _____ Refill: _____

☐ OTHER: _____ Dosage: _____
Sig: _____
QTY: _____ Refill: _____

Prescriber's Name / Practice _____ Office Contact _____
Address _____ Suite# _____ City _____ State _____ ZIP _____
Phone _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

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

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed form to **JERSEY SHORE PHARMACY** at **609.660.0101** Visit us at **WWW.JERSEYSHOREPHARMACYBARNEGAT.COM** for online fillable forms.