GI REFERRAL FORM

Elizabethtown, New York
Phone: 212-941-6480
Toll Free: 888-374-7132
Fax: 888-910-0186
www.ymanningspecialty.com

Today's Date **Anticipated Start Date**

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

PATIENT INFORMATION:

Patient Name _____ DOB_____ Weight_____ ☐ Male ☐ Female
Street Address_____ Apt#_____ City_____ State_____ Zip_____
Daytime Tel_____ Even Tel_____ Cell_____ Email_____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed_____

Insured's Name_____ Relation to Patient_____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#_____
Prescription Card Yes No If Yes, Carrier_____ Tel_____ Fax_____ Policy/Group#_____
Bin#_____ Pcn#_____ RX Group#_____ RXID#_____

PRESCRIBING PHYSICIAN INFORMATION:

Prescriber's Name_____ Office Contact_____
Street Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

CLINICAL INFORMATION:

Diagnosis: _____
ICD-10 Code: _____
Allergies: _____

Medication List:
_____
_____
_____

Current/Prior Therapies:
Please include medication name/strength, duration of rx, and reason for discontinuation
_____
_____
_____

PRESCRIPTION

PLEASE E-SCRIBE & ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **LINZESS (linaclotide) PO daily #30 caps**
☐ **145 mcg PO daily** ☐ **290 mcg PO daily**
Refills: _____

☐ **DEXILANT (dexlansoprazole) PO daily #30 caps**
☐ **30 mg PO daily** ☐ **60 mg PO daily**
Refills: _____

☐ **PYLERA 3 caps PO QID after meals and at bedtime #120 caps**
Refills: _____

☐ **DUEXIS one tablet TID #90 tablets**
Refills: _____

☐ **XIFAXAN (rifaximin)**
☐ **200 mg** ☐ **550 mg**
Sig: _____
Quantity: _____
Refills: _____

☐ **Other:**_____
Sig: _____
Quantity: _____
Refills: _____

☐ **VIBERZI (eluxadoline) PO twice daily #60 tablets**
☐ **75 mg** ☐ **100 mg**
Refills: _____

PRESCRIBER SIGNATURE: (signature required. NO STAMPS) **DATE:**