

GI REFERRAL FORM

Eli abeth St New York
 D \ c b&%&! - (%! * (, S
 Hc: f Y,Y., ' ! ' + (! + %' &
 : U l , , ; ! - % \$! \$ % , * '

 k k kb' ma U b b] b [g d W W h U m a u i b b] b [g " Wc a

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

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:** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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. PLEASE NOTE: Silver Rod can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.