GENERAL
REFERRAL FORM

STAR CARE PHARMACY

175-20 Hillside Avenue
Jamaica, NY 11432
Tel: 718-262-8789
Fax: 718-262-9083

PATIENT INFORMATION

Patient Name:	DOB:	Sex: ❒ M ❒ F	Weight: ❒ lbs. ❒ Kg.
SSN:	Phone:	Allergies:	
Address:	City:	State:	Zip:
Emergency Contact:	Phone:	❒ **Please attach demographic information**	

INSURANCE INFORMATION

❒ **Please attach front and back of patient's insurance card (medical and prescription)**

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: / Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) _____

- Has patient been treated previously for this condition? ❒ Yes ❒ No Medication(s): _____
- Is patient currently on therapy? ❒ Yes ❒ No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❒ Yes ❒ No If yes:
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

❒ **Medication:** _____ Sig: _____ QTY: _____ Refills: _____

❒ **Medication:** _____ Sig: _____ QTY: _____ Refills: _____

❒ **Medication:** _____ Sig: _____ QTY: _____ Refills: _____

❒ **Medication:** _____ Sig: _____ QTY: _____ Refills: _____

❒ **Medication:** _____ Sig: _____ QTY: _____ Refills: _____

Physician's Signature: _____ ❒ **DAW (Dispense as Written)** **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through Star Care Pharmacy, this prescription shall be forwarded to an eligible pharmacy.