



GENERAL REFERRAL FORM

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

STAR CARE PHARMACY

PATIENT INFORMATION			
Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> Kg.
SSN:	Phone:	Allergies:	
Address:	City:	State:	Zip:
Emergency Contact:	Phone:	<input type="checkbox"/> Please attach demographic information	

INSURANCE INFORMATION
<input type="checkbox"/> 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) _____
<ul style="list-style-type: none"> Has patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ <input type="checkbox"/> Medication: _____ Sig: _____ QTY: _____ Refills: _____ <input type="checkbox"/> 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.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. 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 by mistake, then destroy this document. Please direct all verification or notification to Star Care Pharmacy or any of its subsidiaries using the contact information provided on this coversheet.