STAR CARE PHARMACY

"The First Wealth is Health"

175-20 Hillside Avenue • Jamaica, NY 11432
Tel: 718-262-8789 • Fax: 718-262-9083
Toll Free: 888-216-STAR (7827)

NEPHROLOGY REFERRAL FORM

Date: _____ Attn: _____

Ship to ❒ Patient ❒ Physician Office ❒ Nurse/Training

Patient Name _____
Address _____ Suite# _____
City _____ State _____ Zip _____
Home Tel _____ Work Tel _____
Cell _____ Email _____
Date of Birth _____ SS# _____
☐ Male ☐ Female Weight _____ Height _____

Prescriber's Name _____
License# _____ DEA# _____
NPI# _____ UPIN# _____
Practice Name _____
Office Contact _____
Address _____ Suite# _____
City _____ State _____ Zip _____
Tel _____ Fax _____

Insurance Information *(Complete or attach copies of cards)*

Primary Insurance: _____
ID#: _____
Group #: _____

Insured's Name: _____
City: _____ State: _____ Phone: ( ) _____ - _____
Employer: _____

Diagnostic & Clinical Information

ICD-10 Diagnosis Code: ☐ _____ ☐ _____ ☐ _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

☐ Hgb Date_____ ☐ Hct Date_____ ☐ Ferritin Date_____ ☐ Iron Date_____
☐ TIBC Date_____ ☐ Tsat Date_____ ☐ PO_4 Date_____ ☐ Ca Date_____

Prescription

EPOGEN Single Dose Vial: ☐ 2000 units/mL ☐ 3000 units/mL ☐ 4000 units/mL ☐ 10,000 units/mL
Multidose Vial (containing benzyl alcohol): ☐ 20,000 units/2 mL ☐ 20,000 units/1 mL
Sig _____ Qty _____ Refills _____

FOSRENOL ☐ 500mg ☐ 750mg ☐ 1000mg Sig _____ Qty _____ Refills _____

HECTOROL ☐ 0.5mcg ☐ 1.0mcg ☐ 2.5mcg Sig _____ Qty _____ Refills _____

PHOSLO (CALCIUM ACETATE) ☐ 667mg Sig _____ Qty _____ Refills _____

PROCRIT Single Dose Vial: ☐ 2000 units/mL ☐ 3000 units/mL ☐ 4000 units/mL ☐ 10,000 units/mL ☐ 40,000 units/mL
Multidose Vial (containing benzyl alcohol): ☐ 20,000 units/2 mL ☐ 20,000 units/1 mL
Sig _____ Qty _____ Refills _____

RENVELA ☐ 800mg Sig _____ Qty _____ Refills _____

ROCALTROL (CALCITROL) ☐ 0.25mg ☐ 0.5mg Sig _____ Qty _____ Refills _____

SENSIPAR ☐ 30mg ☐ 60mg ☐ 90mg Sig _____ Qty _____ Refills _____

ZEMPLAR ☐ 1mcg ☐ 2mcg ☐ 4mcg Sig _____ Qty _____ Refills _____

OTHER _____ Sig _____ Qty _____ Refills _____

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