



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: _____ Insured's Name: _____
 ID#: _____ City: _____ State: _____ Phone: () _____ - _____
 Group #: _____ 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 _____ PO₄ 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 _____

REVELA 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 _____

IMPORTANT NOTICE: This Facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.