

Oncology Referral Form

TODAY'S DATE:
DATE SHIPMENT NEEDED:
<input type="checkbox"/> NEW START <input type="checkbox"/> CONTINUATION OF THERAPY
SHIP TO: <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> KERR DRUG STORE: _____

GENERAL INFORMATION

PATIENT (FIRST NAME, LAST NAME):		ADDRESS:	
CITY:	STATE:	ZIP:	DOB:
SS#:	HOME#:	CELL#:	WORK#:
ALLERGIES:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT:	WEIGHT:
CURRENT MEDS:			
PHYSICIAN NAME:		PRACTICE NAME/HOSPITAL:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE#:	FAX#:	STATE LIC#:	DEA#:
NURSE/KEY OFFICE CONTACT:		NPI#:	

INSURANCE INFORMATION

PRIMARY INSURANCE:		EMPLOYER:	
CARDHOLDER NAME:	ID#:	GROUP#:	PHONE#:
SECONDARY INSURANCE:	ID#:	GROUP#:	PHONE#:

STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS:	DATE:
ICD-9 Code:	
LAB DATA (as applicable):	DATE DRAWN:
<input type="checkbox"/> Serum creatinine: _____ mg/dL	<input type="checkbox"/> WBC: _____
<input type="checkbox"/> GFR: _____ mL/min	<input type="checkbox"/> HGB/HCT: _____
<input type="checkbox"/> Serum Fe: _____	<input type="checkbox"/> Platelets: _____
<input type="checkbox"/> Ferritin: _____	<input type="checkbox"/> ANC: _____
<input type="checkbox"/> TIBC: _____	
<input type="checkbox"/> % Fe Sat: _____	

CLINICAL INFORMATION

What is the current staging of the patient's disease? _____

Is the patient receiving radiation therapy? Yes No

Does the patient have locally advanced disease? Yes No

Does the patient have metastatic disease? Yes No

Is the patient receiving oral steroids? Yes No

If yes, give name/dose/duration: _____

List previous therapies tried including: drug name, dose, duration, and reasons for failure.

Is patient currently taking? Yes No

_____ Yes No

_____ Yes No

Please provide a list of other medications that the patient is taking as a part of this chemotherapy regimen. Include dose and duration.

PRESCRIPTION INFORMATION

Please enter or affix prescription here or attach as additional page(s) to fax

If you would like brand name, please write "Brand Medically Necessary". Please note that Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified.

Rx

I authorize Kerr Health Specialty Pharmacy and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Physician Signature: _____ Date: _____

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