



ENDOCRINOLOGY REFERRAL FORM

Date Needed _____

26611 Cabot Road Suite B | Laguna Hills CA 92653
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- Phone Order
- Ship to Patient:**
- Home Work
- Ship to:**
- Physician Office
- Nurse / Training
- APS Pharmacy

Patient Name _____ Date of Birth _____ Male Female
 Address _____ Apt # _____ City _____ State _____ Zip _____
 Telephone _____ Cell _____ SSN _____ Email _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

Primary Insurance _____ ID# _____ Group # _____
 Insured's Name _____ Employer _____
 City _____ State _____ Phone _____

ICD-10 Diagnosis Code: Heart (Z94.1) Liver (Z94.4) Pancreas (Z94.83) Kidney (Z94.0) Lung (Z94.2)
 Bone Marrow (Z94.81) Intestines (Z94.82) Peripheral Stem Cells (Z94.84) Other specified organ or tissue (Z94.89) _____
 Date of Diagnosis _____ Date of Transplant _____ Date of Discharge _____ Est. Discharge Time _____
 Was there a prior transplant failure of the same organ? Yes No
 Allergies _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

IMMUNOSUPPRESSANTS

<input type="checkbox"/> PROGRAF® (tacrolimus) <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 5mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> NEORAL® (cyclosporine) <input type="checkbox"/> 25mg <input type="checkbox"/> 100mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> PREDNISONE® <input type="checkbox"/> 5mg QTY _____ Refill x _____ Sig _____
<input type="checkbox"/> RAPAMUNE® (sirolimus) <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> CELLCEPT® (mycophenolate) <input type="checkbox"/> 250mg <input type="checkbox"/> 500mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> OTHER _____ Strength _____ QTY _____ Refill x _____ Sig _____
<input type="checkbox"/> GENGRAF® (cyclosporine) <input type="checkbox"/> 25mg <input type="checkbox"/> 100mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> MYFORTIC® (mycophenolic acid) <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> OTHER _____ Strength _____ QTY _____ Refill x _____ Sig _____

<input type="checkbox"/> PCP PROPHYLAXIS	<input type="checkbox"/> THRUSH (CANDIDA)	<input type="checkbox"/> ANTIHYPERTENSIVES
<input type="checkbox"/> CMV PROPHYLAXIS	<input type="checkbox"/> GASTROINTESTINAL	<input type="checkbox"/> HEMATOPOIETICS
Strength _____	QTY _____ Refill x _____	Sig _____

DIABETIC SUPPLIES

Is patient a Type 1 (insulin-dependent) or Type 2 (non-insulin dependent) diabetic? Not a Diabetic

_____ **GLUCOMETER** **TEST STRIPS** **LANCETS** **INSULIN SYRINGES 0.5cc**

SHORT-ACTING INSULIN _____ **LONG-ACTING INSULIN** _____

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

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

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