HOME PARENTERAL SERVICES

HIV

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Patient information

patient: _____ (last name, first name) female male DOB: _____ SS#: _____

address: _____ (street, city, state, zip)

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ allergies: _____ NKDA

comorbidities: _____ height: _____ weight: _____ lbs kg date: _____

Clinical information

Diagnosis ICD-10_____

New to current therapy? yes no CD4: _____ date: _____ HIV RNA: _____ date: _____

Prescriptions

To order an HIV medication, please either fill out the prescription below OR fax a seperate prescription with this referral form

Drug/Dose/Route/Frequency: _____

_____

_____

Quantity to Dispense: _____

Refills: _____

prescriber + shipping information

prescriber (print): _____ office contact: _____

preferred method of contact: phone fax email preferred contact persons email: _____

ship to: patient office alternate _____ (shipping address: street city state zip)

office address: _____ (street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ (Substitution permitted) _____ (Dispense as Written) date: _____

I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

insurance information: please fax copy of insurance card (front + back)

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