

AllCare Pharmacy Inc.,

PATIENT REFERRAL FORM

HIV/AIDS

FAX: 508. 754. 8878

PATIENT INFORMATION (Please complete this part or attach a copy of patient demographic sheet)

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ Allergies: _____

City: _____ State: _____ Zip: _____ Phone #: _____ SEX _____

INSURANCE INFORMATION (May skip if the patient has Masshealth only. Just provide the SSN)

Primary Insurance: _____ Patient ID #: _____

Phone #: _____ Group #: _____

Secondary Insurance: _____ Patient ID #: _____

Phone #: _____ Group #: _____

PRESCRIPTION INFORMATION

Commonly Prescribed Medication

- ATRIPLA
- COMBIVIR
- EMTRIVA
- EPIVIR
- EPZICOM
- FUZEON
- INTELLENCE
- INVIRASE
- ISENTRESS
- KALETRA
- LEXIVA
- NORVIR
- REYATAZ
- SELZENTRY
- SUSTIVA
- TRIZIVIR
- TRUVADA
- VIRAMUNE
- VIREAD
- ZERIT
- ZIAGEN

AFFIX PRESCRIPTION HERE

PRESCRIBER INFORMATION

Prescriber Name: _____ Tel #: _____

Address: _____ Fax#: _____

City: _____ State: _____ Zip: _____ Date: _____

DATE NEEDED BY: _____

DELIVERY

- TO OFFICE
- TO PATIENT
- OTHER

PRESCRIBERS SIGNATURE: _____

INTERCHANGE IS MANDATED UNLESS THE PROVIDER WRITES THE WORDS " NO SUBSTITUTION" IN THE ABOVE SPACE