



RICHMOND PHARMACY

Specialty Script

PHONE: 718-818-2178 • FAX: 718-818-2179

355 Bard Ave • Staten Island, NY 10310 • www.RichmondSpecialty.com

Date: ____/____/____ Needs by Date: _____

Language: _____ Nursing Instruction Required

Ship to: Patient MD Office

UROLOGY REFERRAL FORM

Prescriber's Name: _____ DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: ____/____/____ Gender: F M

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

Diagnosis: _____	ICD-10: _____	Serum Creatinine: _____
Renal Dysfunction: <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Dysfunction: <input type="checkbox"/> Yes <input type="checkbox"/> No	H/H (Hemoglobin/Hematocrit): _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
<input type="checkbox"/> Eligard*				
<input type="checkbox"/> Casodex*				
<input type="checkbox"/> Firmagon	<input type="checkbox"/> Initial, 240 mg subQ, given as 2 injections of 120 mg each <input type="checkbox"/> Maintenance, 80 mg subQ every 28 days			Delivery to: <input type="checkbox"/> MD <input type="checkbox"/> Patient
<input type="checkbox"/> Lupron *				
<input type="checkbox"/> Nilandron*	<input type="checkbox"/> 150 mg	<input type="checkbox"/> 2 daily for 30 days <input type="checkbox"/> 1 daily for 30 days		
<input type="checkbox"/> Trelstar	<input type="checkbox"/> 3.75 mg IM every 4 weeks <input type="checkbox"/> 11.25 mg IM every 12 weeks <input type="checkbox"/> 22.5 mg IM every 24 weeks			Delivery to: <input type="checkbox"/> MD <input type="checkbox"/> Patient
<input type="checkbox"/> Xgeva *				
<input type="checkbox"/> Zoladex *	<input type="checkbox"/> 250 mg	<input type="checkbox"/> Take 4 tablets daily without food		
<input type="checkbox"/> Zytiga *	<input type="checkbox"/> 5mg	<input type="checkbox"/> 5mg BID with food <input type="checkbox"/> Other:		
<input type="checkbox"/> With Prednisone				

Physician Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile 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 center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter 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.

*For additional information please visit our website www.RichmondSpecialty.com
 ePrescribe to our pharmacy "Richmond Pharmacy Specialty" • (718) 818-2178*