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Specialty Pharmacy Services
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Patient Intake Form-NEPHROLOGY

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE_____ DATE NEEDED_____

PATIENT INFORMATION			
First:	Last:	M.I.:	
Date of Birth:	SSN:	☐Male ☐ Female	
Best Phone:	Alt. Phone:	Email:	
Address:	City:	State:	Zip:

PRESCRIBER INFORMATION			
First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS)

Primary:	PCN:	BIN#	**Secondary:**	PCN:	ID#:
Phone:	ID#:	Group#	Phone:	BIN#	Group#
Prescription Drug Insurer:	Phone:	RxGrp#:	RxBIN#:	PCN/ID#:	

CLINIC INFORMATION			
Diagnosis:	ICD-9:	Diagnosis Date:	
Lab Values: WBC_____ ANC_____ Hgb_____ Hct_____ Plate_____ BSA_____		Height:	Weight:
Medical Justification (Failed Medications, Allergies, etc.):			
Current Therapies/Medications including OTC:			
Is patient currently receiving iron supplement? ☐ Yes ☐ No	Dosage: _____Oral _____IV	Date of Next Injection:	Date of Last Injection:

☑ PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)

DRUG NAME	DOSAGE	PRESCRIPTION ORDERS	QUANTITY	REFILLS
Calcium Carb	☐ 1250mg/5mL Liquid			
Calcium Carb Tabs	☐ 1250 mg			
Calcium Acetate	☐ 667mg			
Renagel	☐ 400mg ☐ 800mg			
Renvela	☐ 800mg			
Fosrenal	☐ 500mg ☐750mg ☐1000mg			
Sensipar	☐ 30mg ☐ 60mg ☐ 90mg			
Zemplar	☐ 1mg ☐ 2mg ☐ 4mg			
Hectorol	☐ 0.5mg ☐ 1mg ☐ 2.5mg ☐			
Vitamin D Capsules	☐ 50 MU			
Epogen	☐ 2M ☐ 3M ☐ 4M ☐ 10M ☐ 20M			
Procrit	☐ 2M ☐ 3M ☐ 4M ☐ 10M ☐ 20M			
Aranesp (mcg/mg)	☐ 25 ☐ 40 ☐ 60 ☐ 100 ☐ 200			

ADDITIONAL INSTRUCTIONS

Please Deliver To: ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home ☐ 3rd Party Facility

Physician's Signature:	Date:

TO BE COMPLETED IF MEDICATION IS BEING SHIPPED TO 3RD PARTY FACILITY

I, _____, a patient of _____, located at_____, appoint the aforementioned facility to act as my agent to order and receive prescriptions on my behalf that have been prescribed by a licensed physician and dispensed by a licensed pharmacist, until I can take possession of them. As a patient of this facility, I have the right to obtain counseling from the pharmacist regarding any medication dispensed by this pharmacy.

Patients's Signature:	Date: