ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

ENDOCRINOLOGY REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Today's Date | Anticipated Start Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

Primary ICD-9 Code Secondary ICD-9 Code Is patient new to therapy? ☐ No ☐ Yes Date of Diagnosis

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

GENOTROPIN Dose/Frequency/Route
Sig
Qty Refills

HUMATROPE Dose/Frequency/Route
Sig
Qty Refills

NORDITROPIN Dose/Frequency/Route
Sig
Qty Refills

OMNITROPE Dose/Frequency/Route
Sig
Qty Refills

SAIZEN Dose/Frequency/Route
Sig
Qty Refills

TEV-TROPIN Dose/Frequency/Route
Sig
Qty Refills

THYROGEN® (THYROTROPIN ALFA FOR INJECTION)
Dose/Frequency/Route
Sig
Qty Refills

CORTROSYN® (COSYNTROPIN FOR INJECTION)
Dose/Frequency/Route
Sig
Qty Refills

FORTEO® (#1 pen) Inject 20mg SQ Daily Qty 1pen w/30 needles Refill x _____

OTHER
Sig
Qty Refills

PLEASE LIST ANCILLARY SUPPLIES IF NEEDED

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

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