ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

OSTEOARTHRITIS PRESCRIPTION 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

☐ 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

ICD-9 Diagnosis Code Description Date of Diagnosis

Patient currently on therapy ☐ Yes ☐ No Date of diagnosis **INSURANCE INFORMATION** Please fax copy of insurance card (front & back)

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

Previous treatments: Yes (specify):

Is this retreatment? ☐ Yes ☐ No Date of last treatment:

Is patient currently on other therapy? ☐ Yes ☐ No ***If yes , treatment to date:***

1) Analgesic
2) NSAIDS
3) Injections ☐ Steroid ☐ Hyaluronic acid If yes, how long ago? _____ months
4) Physiotherapy
5) Occupational Therapy
6) Other

Setting of Care: ☐ Physician's Office ☐ Hospital Outpatient

Scheduled date of service:

Knee being treated: Unilateral ☐ Left ☐ Right ☐ Bilateral (Both)

HIP being treated: Unilateral ☐ Left ☐ Right ☐ Bilateral (Both)

Lower Back being treated: ☐ Yes

Please forward a copy of all the clinical documents but not limited to following

1) X-Ray performed Last performed Date 2) Weight reduction exercise Advised on Date

3) Corticosteroid injection was given ? Injection Given Date

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **Euflexxa** ☐ **Hyalgan** ☐ **Supartz** ☐ **Synvisc One**

☐ **Forteo** ☐ **Orthovisc** ☐ **Synvisc** ☐ **Other**

Dosage

SIG

QTY **Refills**

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

Please fax completed form to St. Jude at 718-417-3621

Visit us at **www.stjuderx.com** for online fillable forms.