

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 _____

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