

FERTILITY REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

- CURRENT PATIENT**
 NEW PATIENT

Patient Name _____ SS# _____ DOB _____ Male Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____
Ship to Patient at Home Work OR Patient will pick up at Physician Office Local Pharmacy Phone _____
Diagnosis _____ Allergies _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

- GONAL-F® RFF 75 IU** # _____ Vials
 GONAL-F® RFF REDI-JECT # _____ 300 IU Pen
_____ 450 IU Pen
_____ 900 IU Pen

Sig: Inject 75-450 units SC QD UD by MD
Refill _____ times

- FOLLISTIM AQ® 300 IU** _____ Cartridges
 FOLLISTIM AQ® 600 IU _____ Cartridges
 FOLLISTIM AQ® 900 IU _____ Cartridges

Sig: Inject 75-450 units SC QD UD by MD
Refill _____ times
 FOLLISTIM PEN DEVICE # _____

- MENOPUR 75 IU** # _____ Vials

Sig: Inject 75-450 units SC QD UD by MD
Refill _____ times

- GANIRELIX 250 mcg PREFILLED SYRINGE** # _____ Syringes
Sig: Inject 1 Prefilled Syringe SC QD UD by MD

- CETROTIDE 0.25 mg** _____ Vials Sig: Inject SC QD UD by MD

- PREGNYL** **NOVAREL** **CHORIONIC GONADOTROPIN** 10,000 IU _____ Vial
Sig: Inject 10,000 IU QD UD by MD Refill _____ times

- OVIDREL 250 mcg** _____ PFS
Sig: Inject Prefilled Syringe SC UD by MD Refill _____ times

- LOW-DOSE HCG** Please include syringes and swabs
 10 units/0.1ml 25 units/0.2ml
 _____ units/_____ml

- CLOMIPHENE CITRATE 50mg** tabs # _____
Sig: Take 1-3 tabs PO QD UD by MD

- LETROZOLE 2.5mg** tabs # _____
Sig: Take 1-3 tabs PO QD UD by MD

- LEUPROLIDE 2 week** _____ Kits
Sig: Inject 0.1ml-0.2ml SC QD UD by MD

- LUPRON DEPOT** 3.75 mg Vial # _____
Sig: Inject 3.75mg IM monthly
Refill _____ times

- LEUPROLIDE TRIGGER** 20IU 40IU 80IU
_____ Prefilled Syringes

- LEUPROLIDE MICRO-DOSE** 40mcg/0.2ml
 500mcg/ml 50mcg/0.2ml
 20mcg/0.2ml 40mcg/0.1ml
Sig: Inject 0.1-0.2ml SC QD UD by MD

- PROGESTERONE INJECTION** 50 mg/ml 10 ml Vial # _____ Vials
 Sesame Oil Olive Oil Ethyl Oleate

Sig: Inject 1ml (50mg) IM QD UD Refill _____ times

- PROMETRIUM** 100 mg 200 mg # _____ Caps
Sig: Use vaginally or orally 1-3 times a day UD by MD Refill _____ times

- CRINONE 8%** # _____ Prefilled Applicators
Sig: Use PV 1-2 times a day UD by MD Refill _____ times

- ENDOMETRIM 100 mg** VAG INSERTS 100 mg # _____ / boxes of 21
Sig: Insert PV 1-3 times a day Refill _____ times

- NORTREL 1/35 21** # _____ packs Sig: One Tab PO QD Starting _____ Date Refills _____

- CLIMARA 0.1 mg PATCH** # _____ patches Sig: Apply UD by MD Refills _____

- VIVELLE DOT 0.1 mg** # _____ patches Sig: Apply 1-4 patches daily UD by MD Refills _____

- ESTRADIOL** 1 mg 2 mg tab # _____ Sig: Take 1-2 tablets PO 1-3 times a day UD by MD Refills _____

- DOXYCYCLINE 100 mg** Caps # _____ Caps Sig: 1 capsule PO BID Refills _____

- METHYLPREDNISOLONE®** 4 mg 8 mg 16 mg # _____ Sig: Take 1 tab PO UD by MD Refills _____

- PRENATAL VITAMINS** # _____ Sig: One tablet a day Refills _____

- OTHER** _____ Sig _____ Qty _____ Refills _____
 OTHER _____ Sig _____ Qty _____ Refills _____

- 3 cc 22 g 1½" Syringes # _____
 3 cc 25 g 1½" Syringes # _____
 3 cc 21 g 1½" Syringes # _____
 27 g x 1/2" Needles # _____
 18 g x 1½" Needles # _____
 25g 5/8" Needles # _____
 ½ cc 29g Insulin Syringes and Needles
Refill _____ times

Anticipated Start Date: _____
 Sharps Package – (Sharps disposal unit, alcohol wipes, gauze, disposal instructions, etc.)
(Please include when dispensing injectables)

Today's Date: _____
 URGENT OVERNIGHT DELIVERY!
 YES! I want separate ship date for:
 Microdose

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space

Additional Notes: _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.