Elwyn SPECIALTY CARE
A BioMatrix Company

FEB 2018

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

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

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

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

☐ **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

☐ **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.

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