Phone: (855) 379-4250
Fax: (225) 243-7957

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HaloCare
Compassionate Care, Divine Service

Dermatology Referral Form

Last Name _____ First _____ DOB (mm/dd/yyyy) _____
Address _____ City _____ State, ZIP _____
Social Security # _____ Is patient age 18 or older? □ Yes □ No □ F □ M
Home Phone: _____ If no, parent/legal guardian name: _____
Cell Phone: _____ Work Phone: _____ Email: _____
Emergency contact name _____ Phone: _____

Primary Insurance Name _____ Policy # _____ Group # _____
Policy Holder Name _____ DOB _____ Insurance Phone # _____
Rx Group Number _____ Bin # _____ PCN # _____

Diagnosis: □ Psoriatic Arthritis (696.0) □ Plaque Psoriasis Mod/Severe (696.1) % BSA: _____
□ Other _____ TB/PPD test: □ POS □ NEG Date: _____
Location: □ Scalp □ Hands □ Nails □ Feet □ Groin Other: _____
Prior med(s) Failed: □ Methotrexate DC Reason: _____ Length of treatment: _____
Other _____ DC Reason: _____ Length of treatment:
_____ DC Reason: _____ Length of treatment:
□ NKDA Allergies: _____

_____ □ Cimzia 200 mg □ 200 mg every other week □ once monthly
□ X 2 PFS □ 400 mg SQ □ at weeks 0, 2, and 4

□ Enbrel □ 25 mg vials □ 50 mg PFS □ Once weekly
□ 25 mg PFS □ 50 mg Sureclick □ twice weekly
□ Other: _____

□ Humira □ 40mg Pen □ SQ once a week □ SQ every other week
□ 40mg PFS □ Other: _____

□ Simponi 50 mg Smartjec □ Simponi 50mg PFS □ SQ once monthly (q 4 wks)

□ Soriatane □ 10 mg cap □ 17.5 mg cap □ 25mg cap

□ Stelara □ 45mg vial □ 90 mg vial □ day 1, week 4, and every 12 weeks

□ Other: _____

Directions: _____ _____
Dispense Quantity: _____ □ 1 month supply Refills: _____

Physician Name _____ NPI # _____ DEA# _____
Address _____ City/State _____ ZIP _____
Phone ( ) _____ Fax # ( ) _____ Office Contact _____
Date: _____
Physician Signature: _____ No stamps please _____

Dispense as written Substitution Allowed