PRINT

Phone: (855) 379-4250
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HaloCare
Compassionate Care, Divine Service

Hepatology 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: □ Chronic Hepatitis C (070.54) □ Hepatocellular Ca (155.0) □ Other (ICD_10): _____
Genotype: _____ Viral Load: _____
□ Other Coinfection: _____ Weight: _____
Prior med(s) _____ DC Reason: _____ Length of treatment: _____
_____ DC Reason: _____ Length of treatment: _____
_____ DC Reason: _____ Length of treatment: _____
□ NKDA Allergies: _____

□ Baraclude	□ 1 mg	□ 5 mg	□ 1 tab daily	
□ Epivir-HBV	□ 100mg		□ 1 tab daily	
□ Hepsera	□ 10mg		□ 1 tab daily	
□ Incivek	□ 375mg		□ 2 tabs 3 x day with food	
□ Neulasta	□ 6mg/0.6ml PFS			
□ Neupogen	□ 300mcg	□ 480mcg		
□ Olysio	□ 150mg cap		□ 1 cap daily with food	
□ Pegasys	□ 135 mcg/0.5ml Proclick	□ 90 mcg SQ once weekly		
	□ 180mcg/.5ml PFS	□ SQ once a week		
	□ 180mcg/ml vial			
	□ 180mcg/.0.5ml Proclick		□ Other: _____	
□ Pegintron	□ 74mcg vial	□ 67.5 mcg Redipen	□ SQ once a week	
	□ 118 mcg vial	□ 108 mcg Redipen		
	□ 177 mcg vial	□ 162 mcg Redipen		
	□ 222 mcg vial	□ 202.5 mcg Redipen		
□ Procrit	□ 2000u/ml	□ 3000 u/ml	□ 4000u/ml	□ 10,000u/ml
	□ 40,000u/ml	□ 20,000 u/ml		□ 20,000 u/2 ml
□ Rebetol	□ 250 mg cap	□ Ribapak _____ mg		□ AM □ PM
	□ 40mg/ml liquid			□ AM & PM
□ Ribasphere	□ 200mg tab	□ 200 mg capsule		
□ Solvadi	□ 400 mg	□ 1 tab daily		□ _____
□ Victrelis	□ 200 mg	□ 4 tablets 3 times daily with food		
□ Viread	□ 300mg	□ 1 tablet daily		

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