PRINT

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

HaloCare
Compassionate Care, Divine Service

Infertility 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: _____ ICD 9 code: _____

Allergies: _____

Prescription: Deliver to: ☐ Pt home ☐ MD office (Md accepts on pts behalf for administration in office)

Bravelle	☐ 75 iu			
Follistim AQ Vial	☐ 75 iu	☐ 150 iu		
Follistum AQ Cartridge	☐ 150 iu	☐ 300 iu	☐ 600 iu	☐ 900 iu
Gonal-F	☐ 450 iu			
Gonal -F RFF vial	☐ 75 iu			
Gonal -F RFF PEN	☐ 300 iu	☐ 450 iu	☐ 900 iu	
HCG	☐ 10,000 iu			
Lupron	☐ 5 mg/ml 14 day			
Cetrotide	☐ 0.25 mg	☐ 3 mg		
Ganirelix	☐ 250 mcg			

Other: _____

Directions: _____

Dispense Quantity: _____ Refills: _____

Physician Name _____ NPI # _____ DEA# _____

Address _____ City/State _____ ZIP _____

Phone ( ) _____ Fax # ( ) _____ Office Contact _____

Date: _____

Physician Signature: _____ No stamps please _____

Dispense as written Substitution Allowed