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

PRINT

HaloCare
Compassionate Care, Divine Service

Pulmonary Arterial Hypertension 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: Pulmonary Arterial Hypertension □ Familial PAH (416.0) □ Idiopathic PAH (416.0)
Other: _____

□ NKDA Allergies: _____

Adcirca □ 20 mg □ Other: _____
Revatio □ 20 mg □ Other: _____
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