



GENERAL PRESCRIPTION REFERRAL FORM

151 Cochituate Rd | Framingham, MA 01701
PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

NEW PATIENT CURRENT PATIENT

Patient Name _____ D.O.B _____ Weight _____ Male Female
 Address _____ City _____ State _____ Zip _____
 Daytime Telephone _____ Evening Telephone _____ Cell _____ Email _____
 Ship to patient at Home Work **OR** Patient will pick up at Physician Office V-Care Pharmacy Date Needed _____
 ICD-10 Code _____ Diagnosis _____ Allergies _____
 Testing Yes No Results _____ Patient currently on therapy Yes No Date of next blood work _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare # _____
 Prescription Card Yes No If yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
 BIN# _____ PCN# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License # _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

Please attach copies of patient's insurance cards

Prescription #1

Medication	Dosage	Quantity	Directions for use	Refills	Signature
_____	_____	_____	_____	_____	_____

Prescription #2

Medication	Dosage	Quantity	Directions for use	Refills	Signature
_____	_____	_____	_____	_____	_____

Prescription #3

Medication	Dosage	Quantity	Directions for use	Refills	Signature
_____	_____	_____	_____	_____	_____

Prescription #4

Medication	Dosage	Quantity	Directions for use	Refills	Signature
_____	_____	_____	_____	_____	_____

Prescription #5

Medication	Dosage	Quantity	Directions for use	Refills	Signature
_____	_____	_____	_____	_____	_____

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) _____ Date _____

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