V-CARE PHARMACY

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** _____