



**Phone: 1-888-315-3395**  
**Fax: 1-888-315-3270**

**Attn:** \_\_\_\_\_

Today's Date: \_\_\_\_\_  
**Date Shipment Needed:** \_\_\_\_\_  
**Ship To:**  Patient  Physician  
 Nursing needed  Training needed  
**Permission to contact pt:**  Yes  No  
 \* All the supplies including syringes and needles will be dispensed if needed.

## Referral Form

### General Information

Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Soc. Sec #: _____ - _____ - _____ Date of Birth: _____ Allergies: _____ Weight: _____ Height: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Physician Name: _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ State Lic #: _____ DEA #: _____ NPI #: _____ Nurse/Key Office Contact: _____
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### Insurance Information

Primary Insurance: _____ Employer: _____ Phone: _____	Cardholder Name: _____ ID#: _____ Group#: _____	Secondary Insurance: _____ ID#: _____ Group#: _____ Phone: _____
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### Statement of Medical Necessity

Primary Diagnosis: _____ _____	ICD 9 Code: _____
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### Prescription Information

R<sub>x</sub>

\*If you would like brand name, please write Medically Necessary.  
 Please note that Axium will dispense our formulary product unless otherwise specified.

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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