TODT HILL PHARMACY
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TRANSPLANT

DATE NEEDED BY ..... SHIP to ☐ PATIENT ☐ OFFICE ☐ OTHER .....

PATIENT INFORMATION

PATIENT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAIN PHONE _____ ALTERNATE PHONE _____

SS# _____ DOB _____

☐ MALE ☐ FEMALE HEIGHT _____ WEIGHT _____ AGE _____

PRESCRIBER INFORMATION

PRESCRIBER NAME _____

DEA # _____ NPI _____ STATE LICENSE# _____

GROUP|HOSPITAL _____

ADDRESS _____

CITY, STATE, ZIP _____

MAIN PHONE _____ FAX _____

CONTACT PERSON _____ PHONE _____

PLEASE FAX COPY OF ☐ PRESCRIPTION CARD FRONT AND BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT AND BACK

CLINICAL INFORMATION

DIAGNOSIS ☐ Z94.0 KIDNEY TRANSPLANT ☐ Z94.83 PANCREAS TRANSPLANT DATE OF TRANSPLANT _____

☐ Z94.4 LIVER TRANSPLANT ☐ Z94.82 INTESTINE TRANSPLANT PRINT LABELS IN ☐ SPANISH ☐ ENGLISH

HEIGHT _____ WEIGHT _____ ALLERGIES _____ ☐ NKDA

MEDICATION	DIRECTION FOR USE	QTY	RF	

☐ M.D. - DEA#, LIC#	☐ M.D. - DEA#, LIC#	☐ M.D. - DEA#, LIC#
☐ M.D. - DEA#, LIC#	☐ M.D. - DEA#, LIC#	☐ M.D. - DEA#, LIC#
CONTACT PERSON ☐	☐	☐

By signing this form and utilizing our services, you are authorizing TODT HILL PHARMACY and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies

PRESCRIBER'S SIGNATURE (no stamp) SUBSTITUTION PERMITTED _____ DATE _____

PRESCRIBER'S SIGNATURE (no stamp) DISPENSE AS WRITTEN _____ DATE _____