UNIVERSAL REFERRAL FORM

Date: _____

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN:_____ Group: _____

DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

Primary Diagnosis: _____ **Therapy**: ☐ New to Therapy ☐ Currently on Therapy, Start Date: _____

Allergies: _____ **Height:** _____ **Weight** _____

PRESCRIPTION INFORMATION

Medication	Form	Strength	Quantity	Dose	Refills	Directions

Other/Notes:_____
_____
_____
_____
_____
_____

Prescriber Signature: _____ **DAW (Dispense as Written)** **Date:** _____

If Century Specialty Script is the patient's choice, please Call-in, Fax, or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353