COTTRILL'S SP
1-844-268-8745

PATIENT REFERRAL FORM

PLEASE INCLUDE ALL MEDICAL RECORDS AND LABS
PLEASE FAX TO 1-716-508-8482

PATIENT INFORMATION

Last Name_____First Name_____ DOB_____

Address_____ City_____ State_____ Zip_____

Gender ☐ Male ☐ Female Height_____ Weight_____ Social Security #_____

Home Phone_____ Cell_____

Allergies_____ Emergency Contact Name_____ Phone_____

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information

Primary Insurance_____ Policy#_____ Group#_____ Phone_____

Policy Holders Name_____ DOB_____

Primary Insurance_____ Policy#_____ Group#_____ Phone_____

Policy Holders Name_____ DOB_____

CLINICAL INFORMATION

Primary Diagnosis:_____ Previous Therapy:_____

Diagnosis Code:_____ Previous Therapy Dates:_____

MEDICATIONS

MEDICATION	STRENGTH	QUANTITY	DIRECTIONS	REFILLS

EDUCATION AND DELIVERY INSTRUCTIONS

Education: ☐ Cottrill's SP to coordinate injection training
☐ Physician's Office to provide injection training

Deliver to: ☐ Patient's Home ☐ Physician's Office
☐ 1st dose to Physician's Office - remaining to Patient Home

PHYSICIAN INFORMATION

Physician Name_____ NPI#_____

License#_____ State_____ DEA#_____

Address_____ City_____ State_____ Zip_____

Phone_____ Fax_____ Office Contact_____

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Product Selection Permitted Dispense as Written Date

Cottrill's will verify insurance benefits, initiate PA's and notify patient prior to admission of any out of pocket expenses or co-payments