

# CYSTIC FIBROSIS REFERRAL FORM



Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
 Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 ICD-10 Diagnosis Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Allergies (please note reaction): \_\_\_\_\_  Latex  
 Current Medications: (list here or attach a medication list): \_\_\_\_\_  
 Comorbidities: (list here or attach a list): \_\_\_\_\_

## INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Tobi (tobramycin)	<input type="checkbox"/> 300mg/5mL Nebulizer Solution	Inhale 300mg via nebulizer every 12 hours. Administer in repeated cycles of 28 days on followed by 28 days off drug.	280mL	
	<input type="checkbox"/> 28mg/capsule Podhaler	Inhale the contents of 4 capsules (112mg total) every 12 hours. Administer in repeated cycles of 28 days on followed by 28 days off drug.	224 capsules	
Other Medication Name:				

Treatment History:  New to Therapy  Continuation of Therapy

Prescriber Information

Prescriber Name: \_\_\_\_\_  
 State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Additional Contact Person Name: \_\_\_\_\_  
 Group or Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_

Product Substitution Permitted

Dispensed as Written

Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

Ship to Patient  Ship to Prescriber/Clinic  Pick up at Albertsons Companies Pharmacy

Date Medication Needed: \_\_\_\_\_

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