St. Matthews Specialty Pharmacy

NEW PATIENT REFERRAL

PATIENT INFORMATION

☐ Substance Use Disorder ☐ Infectious Disease **Administration Date:** _____
Ensure medication is shipped timely.

Patient Name: _____ **Patient DOB:** _____

Patient SSN: _____ **Patient Phone Number:** _____
Required for controlled substances to report to state PDMP.

Patient Allergies: _____

Patient Current Medications: _____

PLEASE HAVE PATIENT SIGN BELOW.

Patient Authorization: I hereby authorize St. Matthews Specialty Pharmacy to contact my prescribing provider to coordinate the delivery, receipt, and storage of my prescription medication for the sole purpose of administration by an authorized provider. I understand that my signature below serves as Patient Ship Authorization. I authorize St. Matthews Specialty Pharmacy to bill my insurance company for this prescription and refills. I understand that I am financially responsible for any co-pay / co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact the Pharmacy if there are changes in my insurance or no longer need this prescription. I or my authorized representative authorize the release of my personal health information and any other information on this enrollment form to third parties, including payors, pharmacy benefit managers, distributors, or their agents, as may be required to investigate, authorize and/or fill my prescription. I understand that I have an offer for prescription counseling by the pharmacist and decline counseling at this time, but understand that I may contact the pharmacy for counseling at any time in the future.

Patient Signature: _____ **Date:**_____
Patient authorization is required to ship medication.

SHIPPING INFORMATION

NOTE: Controlled substances are **required** to be shipped to the prescriber's **DEA Registered Address**.

Provider Name: _____ **DEA #:** _____

Ship to Address: _____

Ship to City: _____ **Ship to State:** _____ **Ship to Zip Code:** _____

Office Phone Number: _____ **Office contact:** _____

Please upload with patient insurance information to our Stream portal or fax to 844-524-4673.