# General Referral Form

Phone: **(318) 673-8360** Fax: **(318) 673-8940**

vitalcare® of SHREVEPORT

| PATIENT DETAILS | | | | | |
|---|---|---|---|---|---|
| **First Name** | **MI** | **Last Name** | | **SSN** | **Home Phone** |
| **Address** | | | | **Date of Birth** | **Cell Phone** |
| **City** | **State** | **Zip** | | **Gender** ☐ Male ☐ Female | **Work Phone** |
| **Shipping Address (if different from Home Address** | | | | **Email Address** | |
| **City** | **State** | **Zip** | | **Best Time of Day to call** | **May we leave a message?** ☐ Yes ☐ No |

| INSURANCE DETAILS | | | |
|---|---|---|---|
| **Are You the Policy Holder?** ☐ Yes ☐ No | **Type of Insurance** ☐ Private Ins ☐ Medicaid ☐ Medicare ☐ Other | | **Policy #:** |
| **Policy Holder Name** | **Relationship to Policy Holder** | **Policy Holder Date of Birth** | **Policy Holder SSN** |

| PROVIDERS & CASE MANAGEMENT | | |
|---|---|---|
| **Primary Provider:** | | **Phone Number** |
| **Provider:** | | **Phone Number** |
| **Case Manager** | **Organization** | **Phone Number** |

| Prescriptions: | | | | | |
|---|---|---|---|---|---|
| **Medication Name** | **Strength** | **Quantity** | **Directions** | **Prescribing Provider** | **Refills** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**OR All RX's have been sent by e-scribe (check here)** ☐

**Blister Packs? Yes** ☐ **No** ☐

**Any allergies or sensitivities to food or drugs? Please explain.**

| Provider's Signature | Date |
|---|---|
| | |

Substitution Permitted ☐ Do Not Substitute ☐