MENTAL HEALTH REFERRAL FORM A













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Prescription

Prescriber

Information Delivery

Patient Name:Phone:	Cell Phone: DOB: City: Diagnosis:	Se	ex: M F
Address:	City:	State: Zi	ip:
ICD-10 Diagnosis Code: Allergies (please note reaction): Current Medications: (list here or	attach a medication list):		Latex
Comorbidities: (list here or attach	n a list):		
INSURANC	CE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD -	- BOTH SIDES	
MEDICATION	DIRECTIONS	QUANTITY	REFILLS
Abilify Maintena (aripiprazole) Kit Syringe	Administer 160mg IM every month Administer 200mg IM every month Administer 300mg IM every month Administer 400mg IM every month	□1 kit/syringe	
Aristada (aripiprazole lauroxil)	Administer 441mg IM every month Administer 662mg IM every month Administer 882mg IM every 6 weeks Administer 1064mg IM every 2 months	☐1 syringe	
Aristada Initio (aripiprazole lauroxil) WITH oral aripiprazole 30mg	Administer 675mg IM one time. Take 1 tablet (30mg) by mouth one time in conjunction with Aristada Initio and Aristada injections	☐ 1 syringe	
Treatment History: New	v to Therapy Continuation of Therapy		
Prescriber Name:State License #:Additional Contact Person Name:	DEA #: NPI:		
Group or Hospital:	Phone:		
	Email Address: City: Sta	ite: Zip:	
The prescriber is to comply with state	duct Substitution Permitted Dispensed as Written specific prescription requirements such as e-prescribing, state specific prescription for sments could result in outreach to the prescriber.		Date
Ship to Patient Ship to P	rescriber/Clinic Pick up at Albertsons Companies Pharmacy Pharmacy	armacist may adm	ninister
Date Medication Needed:			
use of the individual or entity to whic	tion contained in this facsimile message is privileged and confidential information i h it is addressed. If the reader of this message is not the intended recipient, you are g of this communication of the information contained herein is strictly prohibited. If y	hereby notified that	any disclosure,

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MENTAL HEALTH REFERRAL FORM B-I













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Prescription

Prescriber

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atient Name:			DOB:			Sex: M	
atient Name: none: ddress: D-10 Diagnosis Code:	Cell Phone:	City	Ema	II Address:	State:	7in:	
D-10 Diagnosis Code:		Diagnosis:			state	zip	
ergies (please note reaction):						Late	
ergies (please note reaction): Irrent Medications: (list here or							
morbidities: (list here or attach	a list).						
ritorbialies. (list fiere of attach	i d list).						
INSURANC	CE INFORMATION - FAX C	COPY OF PATIENT'S	SINSURANC	CECARD -	BOTH SIDES		
MEDICATION		DIRECTIONS			QUANTITY	REFILL	
	Loading Dose (Day 1): Admi	nister 234mg IM (deltoid	l) on treatment	day 1			
	Follow Up Dose (Day 8): Administer 156mg IM (deltoid) on treatment day 8						
	Maintenance Dose (Day 8)	<u>:</u>					
Invega Sustenna (paliperidone)	Administer 39mg/0.25m	nL IM (deltoid/VG) every	4 weeks		1 kit		
	Administer 78mg/0.5ml	LIM (deltoid/VG) every 4	1 weeks				
	Administer 117mg/0.75m	nL IM (deltoid/VG) every	4 weeks				
	Administer 156mg/1mL I	M (deltoid/VG) every 4 v	weeks				
	Administer 234mg/1.5m	ıL IM (deltoid/VG) every	4 weeks				
	Administer 273mg/0.875m	L IM every 3 months					
	Administer 410mg/1.315mL IM every 3 months						
Invega Trinza (paliperidone)	Administer 546mg/1.75mL	IM every 3 months			1 syringe		
	Administer 819mg/2.625ml	IM every 3 months					
reatment History: New	to Therapy 🗆 C	ontinuation of Th	erapy				
ite of Last Administration:	For Inv	vega only:					
	Day	yldose	_mg	Date:			
	Day	y 8 dose	_mg	Date:			
escriber Name:							
ate License #:	DEA			NPI:			
ditional Contact Person Name:				Dhors			
oup or Hospital: x:	Fm	nail Address:		_ PHONE:			
Idress:		City:		State	e: Zip: _		
escriber Signature: Prod	luct Substitution Permitted		spensed as W	ritten		Date	
e prescriber is to comply with state			•		n, fax language, et		
	ments could result in outreach to				5 5 /-		

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MENTAL HEALTH REFERRAL FORM J-Z















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Patient Name:			DOB:			_ Sex: 🗌 N	Л	□ F
Phone:	Cell Phone:			Email Address:				
Address:		City:			State:	_ Zip:		
ICD-10 Diagnosis Code:		Diagnosis:				· · · · · · · · · · · · · · · · · · ·		
Allergies (please note reaction	on):						Late	X
Current Medications: (list her	on): re or attach a medication list): _							
Comorbidities: (list here or at	ttach a list):							
						_		

INSURAN	ICE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CAI	RD - BOTH SIDES
MEDICATION	DIRECTIONS	QUANTITY REFILLS
Perseris (risperidone)	Administer 90mg subcutaneously in the abdomen once a month. Administer 120mg subcutaneously in the abdomen once a month.	☐ 1 kit
Risperdal Consta (risperidon	Administer 12.5mg IM every 2 weeks Administer 25mg IM every 2 weeks Administer 37.5mg IM every 2 weeks Administer 50mg IM every 2 weeks	1 dose pack
Other Medication Name:		
Treatment History: Ne	w to Therapy Continuation of Therapy	
Prescriber Name:	DEA #: NPI:NPI:	
Additional Contact Person Nam	e:	
Fax:Address:	PhoneEmail Address:City:	state: 7ip:
Prescriber Signature:		
Pro The prescriber is to comply with stat	duct Substitution Permitted Dispensed as Written e specific prescription requirements such as e-prescribing, state specific prescription requirements to the prescriber.	Date on form, fax language, etc. Non-
Ship to Patient Ship to Pr	escriber/Clinic Pick up at Albertsons Companies Pharmacy Date M	Medication Needed:
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