

RECOVERY 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	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Vivitrol (naltrexone)	<input type="checkbox"/> Administer 380mg IM every 4 weeks	<input type="checkbox"/> 1 vial	
Other Medication Name:			

Treatment History: New to Therapy Continuation of Therapy

Date of Last Administration: _____

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 Pharmacist may administer
 Date Medication Needed: _____

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It's as simple as caring.