

MENTAL HEALTH REFERRAL FORM

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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"/> Abilify Maintena (aripiprazole) <input type="checkbox"/> Kit <input type="checkbox"/> Syringe	<input type="checkbox"/> Administer 160mg IM every month <input type="checkbox"/> Administer 200mg IM every month <input type="checkbox"/> Administer 300mg IM every month <input type="checkbox"/> Administer 400mg IM every month	<input type="checkbox"/> 1 unit <input type="checkbox"/> 3 units	
<input type="checkbox"/> Aristada (aripiprazole lauroxil)	<input type="checkbox"/> Administer 441mg IM every month <input type="checkbox"/> Administer 662mg IM every month <input type="checkbox"/> Administer 882mg IM every 6 weeks <input type="checkbox"/> Administer 1064mg IM every 2 months	<input type="checkbox"/> 1 unit <input type="checkbox"/> 3 units	
<input type="checkbox"/> Invega Sustenna (paliperidone)	<input type="checkbox"/> <u>Loading Dose (Day 1)</u> : Administer 234mg IM (deltoid) on treatment day 1 <input type="checkbox"/> <u>Follow Up Dose (Day 8)</u> : Administer 156mg IM (deltoid) on treatment day 8 <input type="checkbox"/> <u>Maintenance Dose (Day 8)</u> : <input type="checkbox"/> Administer 39mg/0.25mL IM (deltoid/VG) every 4 weeks <input type="checkbox"/> Administer 78mg/0.5mL IM (deltoid/VG) every 4 weeks <input type="checkbox"/> Administer 117mg/0.75mL IM (deltoid/VG) every 4 weeks <input type="checkbox"/> Administer 156mg/1mL IM (deltoid/VG) every 4 weeks <input type="checkbox"/> Administer 234mg/1.5mL IM (deltoid/VG) every 4 weeks	<input type="checkbox"/> 1 unit <input type="checkbox"/> 3 units	
<input type="checkbox"/> Invega Trinza (paliperidone)	<input type="checkbox"/> Administer 273mg/0.875mL IM every 3 months <input type="checkbox"/> Administer 410mg/1.315mL IM every 3 months <input type="checkbox"/> Administer 546mg/1.75mL IM every 3 months <input type="checkbox"/> Administer 819mg/2.625mL IM every 3 months	<input type="checkbox"/> 1 unit <input type="checkbox"/> 3 units	

Prescription information continued on next page

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Perseris (risperidone)	<input type="checkbox"/> Administer 90mg subcutaneously in the abdomen once a month. <input type="checkbox"/> Administer 120mg subcutaneously in the abdomen once a month.	<input type="checkbox"/> 1 unit	
<input type="checkbox"/> Risperdal Consta (risperidone)	<input type="checkbox"/> Administer 12.5mg IM every 2 weeks <input type="checkbox"/> Administer 25mg IM every 2 weeks <input type="checkbox"/> Administer 37.5mg IM every 2 weeks <input type="checkbox"/> Administer 50mg IM every 2 weeks	<input type="checkbox"/> 1 unit <input type="checkbox"/> 3 units	
Other Medication Name:			

Treatment History: **New to Therapy** **Continuation of Therapy**

Date of Last Administration:

For Invega only:

Day 1 dose _____ mg Date: _____
 Day 8 dose _____ mg Date: _____

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 _____ Date _____ 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.

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

Date Medication Needed: _____

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