

# RECOVERY 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

Prescription Information

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Vivitrol (naltrexone)	<input type="checkbox"/> Administer 380mg IM every 4 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: \_\_\_\_\_

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

Date Medication Needed: \_\_\_\_\_

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It's as simple as **caring.**

Ph. 800-834-8778  
Fax 877-466-8040

E-Scribe Information:  
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.  
Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100