VITAL Information
Phone: **(800) 652-6157** Fax: **(866) 623-0197**

General Referral Form

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:	**Address**	**Phone Number**
Provider:	**Address**	**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.

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Provider's Signature	Date

Substitution Permitted ☐ Do Not Substitute ☐