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:		Phone Number
Provider:		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.

Provider's Signature	Date

Substitution Permitted ☐ Do Not Substitute ☐