Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

Padek Healthcare Low Molecular Weight Referral Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

ICD-10 Code _____ Diagnosis _____ Duration of treatment From _____ To _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

FRAGMIN

2,500 units/0.2ml	Syringe _____	QTY ____	Refill X _____
5,000 units/0.2ml	Syringe _____	QTY ____	Refill X _____
7,500 units/0.3ml	Syringe _____	QTY ____	Refill X _____
10,000 units/1ml	Syringe _____	QTY ____	Refill X _____
12,500 units/0.5ml	Syringe _____	QTY ____	Refill X _____
15,000 units/0.6ml	Syringe _____	QTY ____	Refill X _____
18,000 units/0.72ml	Syringe _____	QTY ____	Refill X _____

LOVENOX

30mg/0.3ml	Syringe _____	QTY ____	Refill X _____
40mg/0.4ml	Syringe _____	QTY ____	Refill X _____
60mg/0.6ml	Syringe _____	QTY ____	Refill X _____
80mg/0.8ml	Syringe _____	QTY ____	Refill X _____
100mg/1ml	Syringe _____	QTY ____	Refill X _____
120mg/0.8ml	Syringe _____	QTY ____	Refill X _____
150mg/1ml	Syringe _____	QTY ____	Refill X _____

ARIXTRA

2.5mg/0.5ml	Vial _____	QTY ____	Refill X _____
7.5mg/0.6ml	Vial _____	QTY ____	Refill X _____
10mg/0.8ml	Vial _____	QTY ____	Refill X _____

HEPARIN SODIUM

5,000 units/0.2ml	Vial _____	QTY ____	Refill X _____
10,000 units/0.2ml	Vial _____	QTY ____	Refill X _____

OTHER

_____ QTY ____ Refill X _____

By signing this form and utilizing our services, you are authorizing Padek Healthcare and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

PLEASE FAX COMPLETED REFERRAL FORM TO PADEK HEALTHCARE AT 301-277-7127