



# FERTILITY REFERRAL FORM

210 Rock Road | Glen Rock, NJ 07452  
TEL: 201-444-3200 | FAX: 201-444-5792  
Toll Free: 866-888-3200

Today's Date \_\_\_\_\_

**CURRENT PATIENT**  
 **NEW PATIENT**

July 2017

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female  
Street Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
Ship to Patient at  Home  Work OR Patient will pick up at  Physician Office  Local Pharmacy Phone \_\_\_\_\_  
Diagnosis \_\_\_\_\_ Allergies \_\_\_\_\_

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

## REFERRAL SOURCE INFORMATION

<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

## PRESCRIPTION

## PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

<input type="checkbox"/> <b>GONAL-F® RFF 75 IU</b> # _____ Vials <input type="checkbox"/> <b>GONAL-F® RFF REDI-JECT</b> # _____ 300 IU Pen # _____ 450 IU Pen # _____ 900 IU Pen Sig: Inject 75-450 units SC QD UD by MD Refill _____ times	<input type="checkbox"/> <b>FOLLISTIM AQ® 300 IU</b> _____ Cartridges <input type="checkbox"/> <b>FOLLISTIM AQ® 600 IU</b> _____ Cartridges <input type="checkbox"/> <b>FOLLISTIM AQ® 900 IU</b> _____ Cartridges Sig: Inject 75-450 units SC QD UD by MD Refill _____ times <input type="checkbox"/> <b>FOLLISTIM PEN DEVICE</b> # _____	<input type="checkbox"/> <b>MENOPUR 75 IU</b> # _____ Vials Sig: Inject 75-450 units SC QD UD by MD Refill _____ times
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<input type="checkbox"/> <b>GANIRELIX 250 mcg PREFILLED SYRINGE</b> # _____ Syringes Sig: Inject 1 Prefilled Syringe SC QD UD by MD <input type="checkbox"/> <b>CETROTIDE 0.25 mg</b> _____ Vials Sig: Inject SC QD UD by MD	<input type="checkbox"/> <b>LOW-DOSE HCG</b> Please include syringes and swabs <input type="checkbox"/> 10 units/0.1ml <input type="checkbox"/> 25 units/0.2ml <input type="checkbox"/> _____ units/____ml
<input type="checkbox"/> <b>PREGNYL</b> <input type="checkbox"/> <b>NOVAREL</b> <input type="checkbox"/> <b>CHORIONIC GONADOTROPIN</b> 10,000 IU _____ Vial Sig: Inject 10,000 IU QD UD by MD Refill _____ times <input type="checkbox"/> <b>OVIDREL 250 mcg</b> _____ PFS Sig: Inject Prefilled Syringe SC UD by MD Refill _____ times	<input type="checkbox"/> <b>CLOMIPHENE CITRATE 50mg</b> tabs # _____ Sig: Take 1-3 tabs PO QD UD by MD <input type="checkbox"/> <b>LETROZOLE 2.5mg</b> tabs # _____ Sig: Take 1-3 tabs PO QD UD by MD

<input type="checkbox"/> <b>LEUPROLIDE</b> 2 week _____ Kits Sig: Inject 0.1ml-0.2ml SC QD UD by MD <input type="checkbox"/> <b>LUPRON DEPOT</b> 3.75 mg Vial # _____ Sig: Inject 3.75mg IM monthly Refill _____ times <input type="checkbox"/> <b>LEUPROLIDE TRIGGER</b> <input type="checkbox"/> 20IU <input type="checkbox"/> 40IU <input type="checkbox"/> 80IU # _____ Prefilled Syringes <input type="checkbox"/> <b>LEUPROLIDE MICRO-DOSE</b> <input type="checkbox"/> 40mcg/0.2ml <input type="checkbox"/> 500mcg/ml <input type="checkbox"/> 50mcg/0.2ml <input type="checkbox"/> 20mcg/0.2ml <input type="checkbox"/> 40mcg/0.1ml Sig: Inject 0.1-0.2ml SC QD UD by MD	<input type="checkbox"/> <b>PROGESTERONE INJECTION</b> 50 mg/ml 10 ml Vial # _____ Vials <input type="checkbox"/> Sesame Oil <input type="checkbox"/> Olive Oil <input type="checkbox"/> Ethyl Oleate Sig: Inject 1ml (50mg) IM QD UD Refill _____ times <input type="checkbox"/> <b>PROMETRIUM</b> <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg # _____ Caps Sig: Use vaginally or orally 1-3 times a day UD by MD Refill _____ times <input type="checkbox"/> <b>CRINONE 8%</b> # _____ Prefilled Applicators Sig: Use PV 1-2 times a day UD by MD Refill _____ times <input type="checkbox"/> <b>ENDOMETRIM 100 mg</b> VAG INSERTS 100 mg # _____ / boxes of 21 Sig: Insert PV 1-3 times a day Refill _____ times
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<input type="checkbox"/> <b>NORTREL 1/35 21</b> # _____ packs Sig: One Tab PO QD Starting _____ Date Refills _____ <input type="checkbox"/> <b>CLIMARA 0.1 mg PATCH</b> # _____ patches Sig: Apply UD by MD Refills _____ <input type="checkbox"/> <b>VIVELLE DOT 0.1 mg</b> # _____ patches Sig: Apply 1-4 patches daily UD by MD Refills _____ <input type="checkbox"/> <b>ESTRADIOL</b> <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg tab # _____ Sig: Take 1-2 tablets PO 1-3 times a day UD by MD Refills _____	<input type="checkbox"/> 3 cc 22 g 1 1/2" Syringes # _____ <input type="checkbox"/> 3 cc 25 g 1 1/2" Syringes # _____ <input type="checkbox"/> 3 cc 21 g 1 1/2" Syringes # _____ <input type="checkbox"/> 27 g x 1/2" Needles # _____ <input type="checkbox"/> 18 g x 1 1/2" Needles # _____ <input type="checkbox"/> 25g 5/8" Needles # _____ <input type="checkbox"/> 1/2 cc 29g Insulin Syringes and Needles Refill _____ times
<input type="checkbox"/> <b>DOXYCYCLINE 100 mg</b> Caps # _____ Caps Sig: 1 capsule PO BID Refills _____ <input type="checkbox"/> <b>METHYLPREDNISOLONE®</b> <input type="checkbox"/> 4 mg <input type="checkbox"/> 8 mg <input type="checkbox"/> 16 mg # _____ Sig: Take 1 tab PO UD by MD Refills _____ <input type="checkbox"/> <b>PRENATAL VITAMINS</b> # _____ Sig: One tablet a day Refills _____	
<input type="checkbox"/> <b>OTHER</b> _____ Sig _____ Qty _____ Refills _____ <input type="checkbox"/> <b>OTHER</b> _____ Sig _____ Qty _____ Refills _____	

Anticipated Start Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Sharps Package – (Sharps disposal unit, alcohol wipes, gauze, disposal instructions, etc.)  
*(Please include when dispensing injectables)*  
 **URGENT OVERNIGHT DELIVERY!**  
 **YES!** I want separate ship date for: \_\_\_\_\_  
 Microdose

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space

Additional Notes: \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy 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** \_\_\_\_\_

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Please fax completed referral form to **Glen Rock Medical Pharmacy** at 201-444-5792 Visit **www.GLENROCKMEDICALPHARMACY.com** for online fillable forms.

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**GLEN ROCK**

Medical Pharmacy

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**Fax to: 201-444-5792**