Northwestern Medicine®

Sign and fax this form to: 312.694.0108
If you have any questions, please call 312.926.9365
Northwestern Medicine Specialty Pharmacy

GENERAL REFERRAL FORM

PATIENT

PATIENT INFORMATION	
First Name:	MI:
Last Name:	
Patient DOB:	Sex:
Address:	
City/State/ZIP:	
Primary Phone:	Alternate Phone:

PRESCRIBER

PRESCRIBER INFORMATION	
First Name:	Last Name:
Provider NPI:	Provider DEA:
Office Name:	Office Contact:
Address:	
City/State/ZIP:	
Primary Phone:	Fax #:

INSURANCE

FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS

Primary Insurance:	Policy ID #:	
Policyholder Name:	Group #:	
Policyholder DOB:	RX PCN:	RX BIN:
Secondary Insurance:	Policy ID #:	
Policyholder Name:	Group #:	
Policyholder DOB:	RX PCN:	RX BIN:

CLINICAL

CLINICAL			
Primary Diagnosis:		Height:	Weight:
ICD10:	Allergies		
Other Health Conditions:			
Current Medications:			

PRESCRIPTION INFORMATION

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	QTY	DIRECTIONS	RF

You may also e-prescribe to: NW Medicine Specialty Pharmacy

Prescriber Signature and date: Required to validate prescription

❑ Dispense as written/Do not substitute Date

❑ Substitution / Brand exchange permitted Date

For states requiring hand written expressions of product selection use, use this area (e.g., medically necessary, may not substitute, dispense as written, etc.).