Phone: (716) 247-5300 Fax: (716) 681-2270

Patient Referral Form

*Patient Information			
*First Name:	*Last Name:		*Sex (M or F):
*Date of Birth: ____/____/____ (mm/dd/yy)	*Primary Telephone #: ( )		
* Address: Street & Apt. # (PRINT CLEARLY)		Email Address:	
*City:	*State:	*Zip:	*Drug Allergies:

*Third Party Billing (If not indicated prescriptions will be processed as cash)					
*Third Party name:					
*Cardholder ID:		*Group ID:			
BIN:		PCN:			
*Relationship:	Cardholder	Spouse	Child	Other	Person Code: _____

*Credit Card Information (If not indicated, co-payment will be processed through A/R account)	
*Cardholder's Name:	
*Credit card number (1):	*Credit card number (2):
*Expiration Date (MM/YY):	*Expiration Date (MM/YY):
VISA MasterCard DISCOVER Which Type:	VISA MasterCard DISCOVER Which Type:

*Medications Being Ordered					
***Drug Name**	**Directions**	**Strength**	**Quantity**	**Refills**	**Physician**
01.					
02.					
03.					
04.					
05.					
06.					
07.					
08.					
09.					
10.					

Healthcare Provider Information	
* **Physician's Name**:	***Physician's Tel**: ( )
Other Provider's Name:	Other Provider's Tel: ( )
Caregiver's Name:	Caregiver's Tel: ( )
***Previous Pharmacy Name**:	***Pharmacy Tel**: ( )