Adult Growth Hormone Referral Form

BIOMED Pharmaceuticals **Phone: (817) 923-4495** **Toll Free: (866) 923-4495** **Intake Fax: (866) 923-4492**

Corporate Office	Desoto	Houston	Tyler	San Antonio
1512 8th Ave. Suite 100 Fort Worth, TX 76104	2727 Bolton Boone Dr. Ste 110 Desoto, TX 75115	1919 N. Loop West, Ste 180 Houston, TX 77008	837 S. Fleishel Tyler, TX 75701	211 North San Saba, Suite 205 San Antonio, TX 78207

Name: _____ Date of Birth:_____ Allergies:_____

Address:_____ City:_____St._____ Zip_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Male___ Female___

Emergency Contact Name_____ Relationship_____

Primary Insurance: _____

Phone #:_____

Subscriber: _____ DOB: _____

ID#: _____ Policy/Group #: _____

Employer:_____

Secondary Insurance: _____

Phone #:_____

Subscriber: _____ DOB: _____

ID#: _____ Policy/Group #: _____

Employer_____

Prescription Drug Card: Name _____ Group# _____ ID# _____

Diagnosis:

___ Isolated Growth Hormone Deficiency (253.3)
___ Panhypopitutiarism (253.2)
___ Pituitary Neoplasm (237.0)
___ Other (specify ICD-9) _____
___ Iatrogenic Hypopituitarism—hypophysectomy induced, postablative, or radiotherapy-induced (253.7)
___ Other Disorders of pituitary (253.8)

Medical Assessment:

Weight _____(lbs) _____(kg)

GH Stimulation Test Date:_____ Agent:_____ Peak:_____

GH Stimulation Test Date:_____ Agent:_____ Peak:_____

Serum IFG-I Test Date:_____ Result:_____

Normal Range (Age/Sex):_____

Prescription:

Genotropin MQ_____ 0.2mg____ 0.4mg____ 0.6mg____ 0.8mg____ 1mg____ 1.2mg____ 1.4mg____ 1.6mg____ 1.8mg____ 2mg____
Genotropin Pen_____ 5.8mg____ 13.8mg____
Nutropin AQ Pen_____ 10 mg____
Nutropin AQ vial_____10 mg____
Nutropin_____ 5mg____ 10mg____
Protropin_____ 5mg____ 10mg____
Norditropin_____ 4mg____ 8mg____
Humatrope_____ 5mg____ 6mg____ 12mg____ 24mg____
Saizen_____ 5mg____
Omnitrope_____ 1.3 mg / ml-single use vials_____ 5.0 mg / ml-Pen_____

___ Starter Kit
___ Request teach in MD office
___ Request teach in home/AAIC Clinic
___ Pen needles 29g____ 30g____ 31g____
___ BD Ultra Fine
___ Other_____

Dose to be given subcutaneously:

Dose_____ Frequency_____ Days Supply_____ Refills_____(months) Start Date_____

Prescription Special Instructions:_____ Ship By_____

Physician Certification: _____TPI # _____ UPIN# _____Tax ID# _____NPI#

Signature:_____Date_____

Print Name:_____ DEA #_____

Address:_____ City_____ State_____ Zip_____

Phone:_____ Fax:_____ **Thank you for your referral.**

BIOMED **Please send front and back copies of all insurance cards with referral.**

1-16-08