MENTAL HEALTH REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

Albertsons Companies Specialty Care

Jewel Osco · Albertsons · SAFEWAY · VONS · ACME · shaw's · star market · PAVILIONS · CARRS · Randalls · Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ Abilify Maintena (aripiprazole) ☐ Kit ☐ Syringe	☐ Administer 160mg IM every month ☐ Administer 200mg IM every month ☐ Administer 300mg IM every month ☐ Administer 400mg IM every month	☐ 1 unit ☐ 3 units	
☐ Aristada (aripiprazole lauroxil)	☐ Administer 441mg IM every month ☐ Administer 662mg IM every month ☐ Administer 882mg IM every 6 weeks ☐ Administer 1064mg IM every 2 months	☐ 1 unit ☐ 3 units	
☐ Invega Sustenna (paliperidone)	☐ Loading Dose (Day 1): Administer 234mg IM (deltoid) on treatment day 1 ☐ Follow Up Dose (Day 8): Administer 156mg IM (deltoid) on treatment day 8 ☐ Maintenance Dose (Day 8): ☐ Administer 39mg/0.25mL IM (deltoid/VG) every 4 weeks ☐ Administer 78mg/0.5mL IM (deltoid/VG) every 4 weeks ☐ Administer 117mg/0.75mL IM (deltoid/VG) every 4 weeks ☐ Administer 156mg/1mL IM (deltoid/VG) every 4 weeks ☐ Administer 234mg/1.5mL IM (deltoid/VG) every 4 weeks	☐ 1 unit ☐ 3 units	
☐ Invega Trinza (paliperidone)	☐ Administer 273mg/0.875mL IM every 3 months ☐ Administer 410mg/1.315mL IM every 3 months ☐ Administer 546mg/1.75mL IM every 3 months ☐ Administer 819mg/2.625mL IM every 3 months	☐ 1 unit ☐ 3 units	

Prescription information continued on next page

Prescription Information - Continued

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ Risperdal Consta (risperidone)	☐ Administer 12.5mg IM every 2 weeks ☐ Administer 25mg IM every 2 weeks ☐ Administer 37.5mg IM every 2 weeks ☐ Administer 50mg IM every 2 weeks	☐ 1 unit ☐ 3 units	
Other Medication Name:			

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Date of Last Administration:

For Invega only:

Day 1 dose _____ mg Date: _____

Day 8 dose _____ mg Date: _____

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature:

_____ _____ _____ _____

Product Substitution Permitted | Date | Dispensed as Written | Date

Delivery Information

Ship to: ☐ Patient

☐ Prescriber/Clinic

☐ Pick up at an Albertsons Companies Pharmacy

Address: _____

Phone: _____

Date Medication Needed: _____

It's as simple as **caring.**

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E-Scribe Information:
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