Mental Health Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	GENDER: ☐ F ☐ M
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ F20.9 - Schizophrenia, unspecified ☐ F10.20 - Alcohol dependence, uncomplicated ☐ OTHER: __________ - ____________________

☐ F31 - Bipolar Affective Disorder ☐ F11.20 - Opioid dependence, uncomplicated

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any):	APPROX START DATE:	APPROX. END DATE:	REASON FOR DISCONTINUATION:

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA	FIRST DOSE?: ☐ Y ☐ N
	DATE OF LAST DOSE:
	NEXT DOSE DUE BY:
	OTHER:
HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg	

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. MOST RECENT LABS ☐ 3. PATIENT DEMOGRAPHICS ☐ 4. H&P

MEDICATION SELECTION:

Medication	Directions	Quantity / Refills
Abilify Maintena 400MG	☐ INJECT 300 MG IM EVERY 4 WEEKS ☐ INJECT 400 MG IM EVERY 4 WEEKS	QTY: 1 SYRINGE REFILLS: ______
ARISTADA INITIO® aripiprazole lauroxil extended-release injectable suspension	**INDUCTION DOSE:** ☐ INJECT 675 MG IM ONCE ☐ OTHER: ______________________________	QTY: 1 SYRINGE REFILLS: NR
ARISTADA® aripiprazole lauroxil extended-release injectable suspension	**441 MG:** ☐ INJECT 441 MG IM EVERY 4 WEEKS **662 MG** ☐ INJECT 662 MG IM EVERY 4 WEEKS **882 MG:** ☐ INJECT 882 MG IM EVERY 4 WEEKS ☐ INJECT 882 MG IM EVERY 6 WEEKS **1064 MG:** ☐ INJECT 1064 MG IM EVERY 8 WEEKS ☐ OTHER: ______________________________	QTY: 1 SYRINGE REFILLS: ______
Austedo® (deutetrabenazine)	☐ 6 MG BY MOUTH TWICE DAILY ☐ 9 MG BY MOUTH TWICE DAILY ☐ 12 MG BY MOUTH TWICE DAILY ☐ OTHER: _____ MG BY MOUTH ____ TIMES DAILY	QTY: _____ TABS REFILLS: ______
CAPLYTA™ (lumateperone) capsules	☐ 42 MG BY MOUTH ONCE DAILY	QTY: 30 TABS REFILLS: ______

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MEDICATION SELECTION:

Medication	Dosing	Quantity
Fanapt® (iloperidone) tablets	☐ _____ MG BY MOUTH _____ TIMES DAILY	QTY: _____TABS REFILLS:_______
ONCE-DAILY INGREZZA® (valbenazine) capsules	☐ 40 MG BY MOUTH ONCE DAILY ☐ 80 MG BY MOUTH ONCE DAILY	QTY: _____TABS REFILLS:_______
ONCE-MONTHLY INVEGA SUSTENNA® paliperidone palmitate extended-release injectable suspension 39mg, 78mg, 117mg, 156mg, 234mg	☐ 78 MG IM ONCE EVERY 4 WEEKS ☐ 117 MG IM ONCE EVERY 4 WEEKS ☐ 156 MG IM ONCE EVERY 4 WEEKS ☐ 234 MG IM ONCE EVERY 4 WEEKS	QTY: 1 SYRINGE REFILLS:______
INVEGA TRINZA™ paliperidone palmitate extended-release injectable suspension 273 mg, 410 mg, 546 mg, 819 mg	☐ 273 MG IM ONCE EVERY 12 WEEKS ☐ 410 MG IM ONCE EVERY 12 WEEKS ☐ 546 MG IM ONCE EVERY 12 WEEKS ☐ 819 MG IM ONCE EVERY 12 WEEKS	QTY: 1 SYRINGE REFILLS:______
REXULTI™ brexpiprazole tablets	☐ _____ MG BY MOUTH DAILY	QTY: _____TABS REFILLS:______
RisperdalCONSTA risperidone Long-Acting Injection 12.5mg, 25mg, 37.5mg, 50mg	☐ INJECT 25 MG IM EVERY 2 WEEKS ☐ INJECT 37.5 MG IM EVERY 2 WEEKS ☐ INJECT 50 MG IM EVERY 2 WEEKS	QTY: 2 SYRINGE REFILLS:______
Saphris® (asenapine) sublingual tablets 5 and 10 mg	☐ 2.5 MG BY MOUTH TWICE DAILY ☐ 5 MG BY MOUTH TWICE DAILY ☐ 10 MG BY MOUTH TWICE DAILY	QTY: _____TABS REFILLS:______
Vivitrol® (naltrexone for extended-release injectable suspension)	☐ INJECT 380 MG IM EVERY 4 WEEKS	QTY: 1 SYRINGE REFILLS:______
Vraylar® (cariprazine) capsules 1.5mg•3mg•4.5mg•6mg	☐ 1.5 MG BY MOUTH ONCE DAILY ☐ 3 MG BY MOUTH ONCE DAILY ☐ 4.5 MG BY MOUTH ONCE DAILY ☐ 6 MG BY MOUTH ONCE DAILY ☐ OTHER: ______________________________	QTY: 30 TABS REFILLS:______

PATIENT CONSENT & AUTHORIZATION:

I hereby authorize Ivira to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment.
Signature serves as the Patient Ship Authorization.

▶▶▶▶▶▶▶▶ ____

PATIENT SIGNATURE:

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

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PHYSICIAN SIGNATURE: DATE: