ST. VINCENT DE PAUL COMMUNITY PHARMACY REFERRAL FORM

Last Name ___________________ First Name _________________________________ MI ________

Address ____ City ________________________State _____

Zip Code ______________Phone ______________________________ DOB _____/_____/_______

Elderly (62 & older)_____ Nonelderly_____ No. in Household________ Single Parent _____

Check all that are applicable

Ethnicity: ___White ___African American ___Asian ___American Indian ___Hispanic
___Hawaiian or Pacific Islander ___Alaskan native ___Other

Sex: _____ Male _____ Female _____ Transgender Male-Female _____ Unknown
_____ Transgender Female-Male _____ Client refused

Is the patient: ___Uninsured ___have unaffordable Medicare Part D copays
___have unaffordable private insurance copays ___Medicare Gap

OUR PHARMACY IS OPEN MONDAY-FRIDAY 8:30 A.M. TO 4:30 P.M.
OUR PHARMACY IS OPEN FOR PRESCRIPTION PICKUP
MONDAY-FRIDAY FROM 8:30 A.M. UNTIL 12:30 P.M.

OUR SCREENING HOURS FOR NEW CLIENTS ARE MONDAY-FRIDAY 8:30 A.M-11:00 A.M.

PLEASE HAVE PATIENT BRING IN THE INFORMATION BELOW TO RECEIVE FREE MEDICATION THROUGH OUR PROGRAM

-PICTURE ID (VALID DRIVERS LICENSE OR STATE ID) OR PASSPORT
-CURRENT PRESCRIPTION OR ELECTRONIC ESCRIBE
-DISCHARGE PAPERS FROM HOSPITAL

WE ARE LOCATED AT: 1647 CONVENTION STREET, BATON ROUGE, LA 70802
(225) 383-7450 PHONE (225) 383-4774 FAX

WE DO NOT DISPENSE ANY NARCOTICS OR CONTROLLED SUBSTANCES

REFERRING AGENCY NAME ______________________________________DATE____________

REFERRING AGENCY SIGNATURE ____