XUBEX® Specialty Pharmacy Services
www.Xubex.com

# Patient Intake Form-MENTAL HEALTH

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE_____ DATE NEEDED_____

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| First: | Last: | M.I.: | ☐Male ☐ Female | |
| Date of Birth: | SSN: | | Best Phone: | |
| Address: | City: | | State: | Zip: |
| Shipping Address (if different from home address): | | | Height: | Weight: |

| PRESCRIBER INFORMATION | | | |
|---|---|---|---|
| First: | Last: | M.I.: | |
| DEA#: | Med. Lic. #: | NPI#: | |
| Office Contact: | Phone: | Alt. Phone: | |
| Address: | City: | State: | Zip: |

| INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS) | | | |
|---|---|---|---|
| **Name of Insured:** | Insurance Company: | ID#: | |
| Phone: | BIN# | PCN: | Group# |

**CLINICAL INFORMATION**

Diagnosis: ICD_____ ICD_____ ICD_____ ICD_____ ICD_____ ICD_____ ICD_____ ICD_____

**☑ PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)**

| Medication | Dose | Qty | Refill | Medication | Dose | Qty | Refill |
|---|---|---|---|---|---|---|---|
| ☐ Abilify Tablets | | | | ☐ Invega Sustenna | 117mg | | |
| ☐ Abilify Injection | 9.75mg | | | ☐ Invega Sustenna | 156mg | | |
| ☐ Clozapine Tablets | 25mg | | | ☐ Invega Sustenna | 234mg | | |
| ☐ Clozapine Tablets | 100mg | | | ☐ Latuda Capsules | | | |
| ☐ Geodon Capsules | | | | ☐ Risperdol Consta | 12.5mg | | |
| ☐ Diphenhydramine | 50mg/mL | | | ☐ Risperdol Consta | 25mg | | |
| ☐ Epipen Injection | | | | ☐ Risperdol Consta | 37.5mg | | |
| ☐ Epipen Jr. | | | | ☐ Risperdol Consta | 50mg | | |
| ☐ Fluphenazine Injection | 25mg/mL | | | ☐ Risperdol Tablets | | | |
| ☐ Haldol | 5mg/mL | | | ☐ Seroquel XR Tablets | | | |
| ☐ Haldol DEC | 50mg/mL | | | ☐ Seroquel Tablets | | | |
| ☐ Haldol DEC | 100mg/mL | | | ☐ _____ | | | |
| ☐ Invega Tablets | 1.5mg | | | ☐ _____ | | | |
| ☐ Invega Tablets | 3mg | | | ☐ _____ | | | |
| ☐ Invega Tablets | 6mg | | | ☐ _____ | | | |
| ☐ Invega Tablets | 9mg | | | | | | |

**DIRECTIONS**

**ADDITIONAL INSTRUCTIONS**

**Please Deliver To:** ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home

**Physician's Signature:** Date: