



Phone: 1-888-899-7447
Fax: 1-866-368-9808

CAP Psychiatry Patient Order Form

PATIENT INFORMATION

Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies		<input type="checkbox"/> NKDA
Date of Birth		SSN#	Weight _____		<input type="checkbox"/> kg <input type="checkbox"/> lb Date
Address		City	State	Zip	
Phone # (Home)		(Work)	Email address (optional)		

INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)

Primary Insurance		Medicare ID
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

DIAGNOSIS INFORMATION (Please specify primary and secondary diagnoses)

Primary ICD-9	Secondary ICD-9
Is patient new to therapy? <input type="checkbox"/> yes <input type="checkbox"/> no Date of diagnosis	

PRESCRIPTION INFORMATION

Medication	Dose	Directions/Frequency of Administration	Total # Doses
<input type="checkbox"/> Haloperidol Decanoate Inj	___mg IM		
<input type="checkbox"/> Fluphenazine Decanoate Inj 25 mg/mL	___mg IM ___mg SQ		
<input type="checkbox"/> Risperdal Consta® Inj	<input type="checkbox"/> 25 mg IM <input type="checkbox"/> 37.5 mg IM <input type="checkbox"/> 50 mg IM <input type="checkbox"/> ___mg IM		
<input type="checkbox"/>			

DELIVERY INSTRUCTIONS

Order will be shipped to the address provided below. Physician must be registered with CAP at this location and this must be the site of administration.	Administration Date *
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PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address		City/State/Zip
DEA #		UPIN #
CAP PIN #		NPI #

Physician's Signature _____ **Date** _____
(required to process prescription – stamped signatures are not permissible)

R (12/28/06)

If this order is needed in less than 48 hours please call 888-899-7447 to place order.