Botox Referral Form (Hyperhidrosis)

357 Flatbush Ave • Brooklyn, NY 11238
Ph (718) 230-3535 • Fax (718) 230-0596 • Alt Fax (718) 230-0390

SHIP TO:	❑ Patient's Home	❑ Provider's Office	❑ Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: ❑ M ❑ F
Patient Address: (include apt. #)			City:	State: / Zip:
Home Phone:	Work Phone:		Cell Phone:	Primary Language:

PHARMACY INSURANCEINFORMATION:

Primary Insurance Name:	Insured's SSN:	Patient ID#:
Rx BIN#:	Rx PCN#:	Rx Group#:

****Please include a copy of the front and back of the patient's pharmacy insurance card with this form****

PRESCRIBING PHYSICIAN INFORMATION:

Physician Name:	Specialty:	Contact Name:
Physician Address:	Phone #:	Secure Fax #:
Physician DEA # :	Physician NPI #:	License #:

CLINICAL INFORMATION:

Diagnosis:

- ❑ L74.510 - Primary focal hyperhidrosis, axilla
- ❑ L74.511 - Primary focal hyperhidrosis, face
- ❑ L74.512 - Primary focal hyperhidrosis, palms
- ❑ L74.513 - Primary focal hyperhidrosis, soles
- ❑ L74.519 - Primary focal hyperhidrosis, unspecified
- ❑ L74.52 - Secondary focal hyperhidrosis
- ❑ Other: ____

❑ New start ❑ Reauthorization ❑ Restrart

Allergies:

Med List:

Height: ❑in ❑cm

Weight: ❑lb ❑kg

MEDICATIONS TRIED AND FAILED:

Medication Name and Strength	Route	Frequency	Approx. Date Range Therapy Began and Stopped	Outcome
			______/______ to ______/______	
			______/______ to ______/______	
			______/______ to ______/______	

PRESCRIPTION INFORMATION:

****Please include an original prescription with this form or E-scribe a prescription to Kings Pharmacy****

Medication	Strength	Directions	Quantity	Refills
❑ BOTOX®	❑ 50U ❑ 100U ❑ 200U			
❑				
❑				

PRESCRIBER SIGNATURE: **DATE:**

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