AVANT
PHARMACY & WELLNESS CENTER

Infectious Disease Referral Form

Please fax completed referral form to Avant Wellness, PLLC
(980)446-1445
Please contact office for questions:
(980)446-1445

PATIENT DEMOGRAPHICS:

PATIENT NAME: _____ PREFERRED CONTACT #: _____

DATE OF REFERRAL: _____ SECONDARY CONTACT #: _____

SOCIAL SECURITY NUMBER: _____ ADDRESS: _____

DATE OF BIRTH: _____ GENDER: ☐ F ☐ M CITY, STATE, ZIP: _____

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ B20 - Human immunodeficiency virus ☐ PrEP **Date of Diagnosis:** _____

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

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

CLINICAL INFORMATION:

ALLERGIES: ☐ NKDA
TREATMENT NAIVE: ☐ Y ☐ N
LAST DOSE: _____

HEP B TEST COMPLETED? ☐ Y ☐ N
HEP C TEST COMPLETED? ☐ Y ☐ N
HLA-B*5701 TEST COMPLETED? ☐ Y ☐ N

CD4 COUNT: _____
VIRAL LOAD: _____ DATE OF LABS: _____
SERUM CREATININE: _____

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

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

MEDICATION SELECTION:

MEDICATION	DOSE/STRENGTH	SIG	QTY	RF#
☐ BIKTARVY	☐ 50/200/25 MG TAB			
☐ CIMDUO	☐ 300/300 MG TAB			
☐ DESCOVY	☐ 200/25 MG TAB			
☐ DOVATO	☐ 50/300 MG TAB			
☐ EPZICOM	☐ 600/300 MG TAB			
☐ GENVOYA	☐ 150/150/200/10MG			
☐ INTELENCE	☐ 25 MG TAB ☐ 100 MG TAB ☐ 200 MG TAB			
☐ ISENTRESS	☐ 25 MG CHEW TAB ☐ 100 MG CHEW TAB ☐ 100 MG SUSP. ☐ 400 MG TAB			
☐ ISENTRESS HD	☐ 600 MG TAB			
☐ JULUCA	☐ 50/25 MG TAB			
☐ NORVIR	☐ 100 MG TAB ☐ 80 MG/ML SOLN			

MEDICATION	DOSE/STRENGTH	SIG	QTY	RF#
☐ ODEFSEY	☐ 50/200/25 MG TAB			
☐ PREZCOBIX	☐ 800/150 MG TAB			
☐ PREZISTA	☐ 75 MG TAB ☐ 150 MG TAB ☐ 600 MG TAB ☐ 800 MG TAB ☐ 100 MG/ML SUSP			
☐ REYATAZ	☐ 150 MG CAP ☐ 200 MG CAP ☐ 300 MG CAP ☐ 50 MG POWDER			
☐ RUKOBIA	☐ 600 MG TAB			
☐ SYMTUZA	☐ 800/150/200/10 TAB			
☐ TIVICAY	☐ 10 MG TAB ☐ 25 MG TAB ☐ 50 MG TAB			
☐ TRIUMEQ	☐ 600/50/300 MG TAB			
☐ TRUVADA ☐ _____	☐ _____ ☐ _____			

PRESCRIBER INFORMATION:

PHYSICIAN NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ LICENSE #: _____

CITY, STATE, ZIP: _____ NPI: _____

PHYSICIAN SIGNATURE: _____ DATE: _____