E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

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Endocrinology

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____
ICD-10 Code: _____
Height: _____ ft _____ inches Weight: _____ lbs
Allergies: _____

Has the patient been treated previously for this condition?
☐ Yes ☐ No
Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:		Directions:	Quantity:	Refills:
Afrezza®	Titration Pack: ☐ 4 and 8 Unit ☐ 4,8 & 12 Unit	Cartridge: ☐ 4-Unit cartridge ☐ 8-Unit cartridge	☐ Administer _____ mcg subcutaneously three times a day ☐ Other	☐ 4 week supply	
Sandostatin®	Ampules: ☐ 50mcg/ml ☐ 100mcg/ml ☐ 500mcg/ml	Multi-Dose Vial: ☐ 200 mcg/ml (5ml) ☐ 1000 mcg/ml (5ml)	☐ Administer _____ mcg SC three times a day ☐ Other	☐ 4 week supply ☐ 12 week supply	
Sandostatin® Lar	☐ 10 mg vial kit ☐ 20 mg vial kit ☐ 30mg vial kit		☐ Mix the contents of one vial with diluent and administer intragluteally every 4 weeks ☐ Other	☐ 4 week supply ☐ 12 week supply	
Sensipar®	☐ 30 mg tablet ☐ 60 mg tablet ☐ 90 mg tablet		☐ Take ____ mg by mouth once daily with food ☐ Other	☐ 4 week supply ☐ 12 week supply	
Somatuline® Depot	☐ 60 mg prefilled syringe ☐ 90 mg prefilled syringe ☐ 120 mg prefilled syringe		☐ Inject _____ mg SC (1 syringe) every 4 weeks	☐ 4 week supply ☐ 12 week supply	
Other					

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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