NOBLE HEALTH SERVICES

UROLOGY

E-SCRIBE and FAX ENROLLMENT FORM

☐ **NOBLE NORTHEAST:** E-Scribe: **NOBLE** | Fax: **888-842-3977** | Tel: 888-843-2040

☐ **NOBLE SOUTHEAST:** E-Scribe: **NOBLEMS/TRANSCRIPT** | Fax: **601-420-4040** | Tel: 866-420-4041

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

PATIENT INFORMATION	PROVIDER INFORMATION
Patient Name: _____ ☐ Male	Prescriber's Name: _____
Street Address: _____ ☐ Female	Office Contact Name: _____
City: _____ State: ____ Zip Code: _____	Address: _____
Phone Number: _____	City: _____ State: ____ Zip Code: _____
Email Address: _____	Phone Number: _____
Last Four of Social: _____ Date of Birth: _____	Fax Number: _____
Translator Needed: ☐ Yes ☐ No Language: _____	DEA/NPI #: _____

INSURANCE - PLEASE FAX A COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ ins Weight: _____ lbs

Allergies: _____

Other Notes: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____

Medications On: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Afinitor®	☐ 2.5 mg tablet ☐ 5 mg tablet ☐ 7.5 tablet ☐ 10mg tablet	☐ Take once daily ☐ Other	☐ 4-week supply	
Afinitor Disperz®	☐ 2mg oral solution ☐ 2mg oral solution ☐ 5mg oral solution	☐ Take once daily ☐ Other	☐ 4-week supply	
tadalafil	☐ 2.5mg ☐ 5mg ☐ 10mg ☐ 20mg			
sildenafil	☐ 25mg ☐ 50mg ☐ 100mg			
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____