ASP CARES

Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

☐ New Patient

Date

Patient Name_____DOB_____Weight_____ ☐ Male ☐ Female

Street Address:_____Apt #_____City_____State_____Zip_____

Phone #_____Cell #_____Allergies_____

ICD 10 Code: _____

℞

ALL controlled substance quantities must be hand written in number and letter form

Prescriber's Name _____ Office Contact_____

Street Address _____Suite #_____ City _____ State _____ Zip _____

Telephone_____ License # _____ NPI # _____ DPS # _____ DEA #_____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

IMPORTANCE NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable laws. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Medicare and Medicaid or another state funded program will not cover above mentioned products. Co-payments due at dispensing of the medication

FDA BLACK BOX WARNING: [NSAID] may cause an increased risk of serious cardiovascular thrombotic event, myocardial-infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk.

Please fax completed form to 1 (888) 294-9434