

REFERRAL FORM

Patient's Name _____ Phone (____) _____ Alt. Phone (____) _____

Address _____

City/State/Zip _____

Patient's DOB _____ Sex M F Height _____ Weight _____ Social Security No. _____

Diagnosis _____

Ship Meds to Home Work Doctor's Office Other _____ Medication Needed By _____

Caregiver's Name _____

May Axium Healthcare Pharmacy, Inc., contact the caregiver? _____

Insurance Information (Please submit a copy of the front and back of the insurance card if possible)

Primary Insurance _____ Cardholder's Name _____

Relationship _____ ID No. _____ GRP No. _____ Phone _____

Secondary Insurance _____ Cardholder's Name _____

Relationship _____ ID No. _____ GRP No. _____ Phone _____



DIASTAT[®] AcuDial[™] (diazepam rectal gel) Dosing Recommendations (by age and weight)

2 to 5 years 0.5 mg/kg		6 to 11 years 0.3 mg/kg		12+ years 0.2 mg/kg	
Weight (kg)	Dose (mg)	Weight (kg)	Dose (mg)	Weight (kg)	Dose (mg)
6 to 10	5	10 to 16	5	14 to 25	5
11 to 15	7.5	17 to 25	7.5	26 to 37	7.5
16 to 20	10	26 to 33	10	38 to 50	10
21 to 25	12.5	34 to 41	12.5	51 to 62	12.5
26 to 30	15	42 to 50	15	63 to 75	15
31 to 35	17.5	51 to 58	17.5	76 to 87	17.5
36 to 44	20	59 to 74	20	88 to 111	20

**In NY, place Rx here and
fax to 1-877-422-8435 AND
mail to: Axium Healthcare Pharmacy
550 Technology Park
Lake Mary, FL 32746**

DIASTAT[®] AcuDial[™] (diazepam rectal gel)

10 mg Twin Pack with 4.4 cm rectal tip

Dialed to 5 mg 7.5 mg 10 mg

Quantity: Twin Packs (circle; max 5 packs per 30 days)

2 3 4 5 Other _____

Refills 0 1 2 3 4 5

SIG: Administer rectally as directed by prescriber

Other _____

20 mg Twin Pack with 6.0 cm rectal tip

Dialed to 12.5 mg 15 mg 17.5 mg 20 mg

Quantity: Twin Packs (circle; max 5 packs per 30 days)

2 3 4 5 Other _____

Refills 0 1 2 3 4 5

SIG: Administer rectally as directed by prescriber

Other _____

DIASTAT[®]: 2.5 mg Twin Pack with 4.4 cm rectal tip

Quantity: Twin Packs (circle; max 5 packs per 30 days)

2 3 4 5 Other _____

Refills 0 1 2 3 4 5

SIG: Administer rectally as directed by prescriber

Other _____

Physician Information

Physician _____ State Lic. No. _____ DEA No. _____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Contact _____

Physician's Signature _____ Date _____