

BEHAVIORAL HEALTH

E-SCRIBE and FAX ENROLLMENT FORM

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

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

Delivery Needed By:	Delive	er to: 🗌 Patient's	Home 🗌 Physici	an's Office [] Other	:		
PATIENT	INFORMATIC)N	F	PRESCRIBE	R INFC	ORMATION		
Patient Name:		Male: [Prescriber:					
Address:Female:			Office Contact:	Office Contact:				
City:	State:	Zip:	Address:					
Phone: Er	e: Email:			City:Zip:				
Last 4 of SSN:	DOB:		_ Phone:	Phone: Fax:				
Translator: Yes 🗌 No 🗌	Language:		DEA/NPI #:					
Patient interested in: Support	Signature: Date:							
INSURANCE INFOR	MATION - PI	LEASE FAX A (OPY OF FRON	Г & ВАСК С	F PRE	SCRIPTIO	N CARD	
		CLINICAL	INFORMATION					
Diagnosis:	_ ICD-10 Code:	ICD-10 Code:						
Has the patient been treated	previously for t	this condition: Ye	s 🗌 No 🗌 🛛 He	eight:	ft	_in Weight	: lbs	
Allergies:	Medications On:							
Other Notes:			_ Medications Faile	ed:				
LO	CATION OF	ADMINISTRATI	ON AND SHIPP	ING INFOR	ΜΑΤΙΟ	N		
Location of Administration:	Additional Ship	Additional Shipping Instructions? Yes 🗌 No 🗌						
PI: DEA:			If YES, please specify:					
Address:	ress: Suite:			MEDICATION INSTRUCTIONS FOR PHARMACY				
ity: State: Zip:			Is this medication a new start? Yes \square No \square					
Phone: Fax:			If NO, please provide:					
Date Needed for Medication:			_ Initiation Date:	Initiation Date: Date of Last Dose:				
		MEDICATIO	N INFORMATIO	N				
🗌 Abilify Maintena		🗌 Invega Sustenn	a	Sublocade*				
🗌 Aristada		🗌 Olanzapine		Vivitrol (naltrexone IM)				
Haloperidol deconate		Risperdal			ther:			
Dosage/Strength:	Rout Adminis		Directions:	Quar	tity:	Refills:	Dispense as Written:	
	🗌 Pen							
	Starter K	lit						
	Tablet							
	Topical							

* Prescribers must comply with their state-specific controlled substance prescribing requirement

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