EVENTUS RX
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HIV
Patient Referral Form

Patient Information

Patient Full Name:

Date of Birth: Social Security:

Phone: Sex: Height: Weight:

Address:

City: State: Zip:

Prescriber Name: Address:

DEA#: NPI: Phone:

Signature: Date:

Diagnosis Information

Diagnosis:

Secondary Dx:

CD4 Count:

Viral Load:

sCr:

Date of Lab:

Prep?:

Prescription Information

❑ Aptivus®	❑ Genvoya®	❑ Selzentry®	❑ ___________
❑ Atripla®	❑ Intelence®	❑ Stribild®	❑ ___________
❑ Biktarvy®	❑ Invirase®	❑ Sustiva®	❑ ___________
❑ Combivir®	❑ Isentress®	❑ Tivicay®	❑ ___________
❑ Complera®	❑ Juluca®	❑ Triumeq®	❑ ___________
❑ Descovy®	❑ Kaletra®	❑ Trizivir®	❑ ___________
❑ Edurant®	❑ Lexiva®	❑ Truvada®	❑ ___________
❑ Emtriva®	❑ Norvir®	❑ VALCYTE®	❑ ___________
❑ Epivir®	❑ Odefsey®	❑ Viramune®	❑ ___________
❑ Epzicom®	❑ Prezcobix®	❑ Viread®	❑ ___________
❑ Evotaz®	❑ Prezista®	❑ Vitekta®	❑ ___________
❑ Fuzeon®	❑ Reyataz®	❑ Ziagen®	❑ ___________

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Prescriber's Signature (no stamps) Date

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