bedard PHARMACY

Omnipod Referral Form

Complete and Return
Fax to (207) 333-3271

PATIENT INFORMATION

Patient Name: ____________________ Date of Birth: ____________________

Patient Address: ____________________ Phone Number: ____________________

Patient Email Address: ____________________

PROVIDER INFORMATION

Healthcare Provider Name: ____________________ NPI: ____________________

Hospital/Clinic Name: ____________________

Address: ____________________ Phone: ____________ Fax: ____________

Healthcare Provider Signature: ____________________ Date: ____________________

Healthcare Provider Email Address: ____________________

ORDER INFORMATION

Intro Kit Quantity MUST Match Pod Quantity

1. Initial Order Option (Select One)

Omnipod Dash Intro Kit Quantity 1

Change pod: ☐ Every 24 hours ☐ Every 36 hours
☐ Every 48 hours ☐ Every 72 hours ☐ Every ____ hours

Omnipod 5 DexG7G6 Intro Kit Quantity 1

Change pod: ☐ Every 24 hours ☐ Every 36 hours
☐ Every 48 hours ☐ Every 72 hours ☐ Every ____ hours

Omnipod 5 Libre2Plus G6 Intro Kit Quantity 1

Change pod: ☐ Every 24 hours ☐Every 36 hours
☐ Every 48 hours ☐ Every 72 hours ☐ Every ____ hours

2. Pods (Select One)

Pod Type: ☐ **Libre2+/G6** ☐ **Dash** ☐ **Dexcom G6-G7**

Quantity: ☐90 ☐45 ☐30 ☐15 ☐10 ☐ Other:_______

Directions: Change 1 pod ☐ Every 24 hours ☐ Every 36 hours
☐ Every 48 hours ☐ Every 72 hours ☐ Every ____ hours

3. Prescription Details

Number of Refills: ____________________ Dispense as Written: ________________

Phone: (207) 784-3700
Option 1 for Pharmacy

Fax: (207) 333-3271

www.MyBedard.com