SIMILAC® PM 60/40 MEDICAL REFERRAL FORM

All fields must be completed.
Please fax the finished form to 877-295-2775 or email to AN-HCP-REFERRAL@abbott.com

Patient Name: ____________________

Patient Date of Birth: ____________________

Patient Shipping Address:

Street: ____________________

City: ____________________ State: __________ Zip Code: __________

Parent/Caregiver Name (if patient is under 18): ____________________

Parent/Caregiver Phone Number: ____________________

Parent/Caregiver Email Address: ____________________

Amount of Similac PM 60/40: __________ cases per month*

Duration of Use: ☐ **3 months** ***or*** ☐ **6 months** ***or*** ☐ **12 months**

Physician Name: ____________________

Physician Phone Number: ____________________

DEA or NPI Number: ____________________

Physician Signature: ____________________ Date: __________

By submitting this form and your patient's information, you represent and warrant that you've obtained any necessary consents or authorizations from your patient to disclose their information to Abbott Nutrition and its contracted third parties.

* Each case of Similac 60/40 includes six 400g cans.

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