



Sona Access Referral Form

For Asheville patient referrals, please fax: 828-298-8190

For Hendersonville patient referrals, please fax: 828-698-7714

Or email all referrals to: referrals@sonapharmacy.com

Please fill out as much of the below form as possible

Referral Source (Name, Agency, and Phone number):		Date:	
Reason for referral: <input type="checkbox"/> Complex medication regimen <input type="checkbox"/> Adherence concern <input type="checkbox"/> Delivery <input type="checkbox"/> Transitions of care (i.e. LTC, Home, Facility, Hospital)			
PATIENT INFORMATION			
Patient Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: Social Security Number:
Street address:		City, State and Zip Code:	
Best time to contact: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon	Primary Number:	Secondary Number:	
Home Visit Date and Time:		Discharge Date (i.e. Facility, Home Health, Hospital):	
Caregiver/Secondary Contact Name:		Phone Number:	Relation:
Allergies:		Health Conditions:	
Primary Doctor Name; Contact:		Specialist Doctor Name; Contact:	
Current Pharmacy Name, Location, Contact:		Easy Open Tops: <input type="checkbox"/> Yes <input type="checkbox"/> No	
INSURANCE INFORMATION			
(Please make a copy of front and back of Insurance card if available)			
Please indicate primary insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> NC Medicaid	<input type="checkbox"/> Commercial Insurance <input type="checkbox"/> Cash/No Insurance
PHARMACY INFORMATION			
Pharmacy Location will be determined by the Sona Access staff based on delivery address			
Sona Pharmacy (Asheville):	805 Fairview Rd Asheville NC 28803 Phone: 828-348-3000 Fax: 828-298-8190 Mon-Fri: 8 am - 8 pm, Sat: 9 am – 6 pm, Sun: 11 am - 6 pm		
Sona Pharmacy (Hendersonville):	600 Carolina Village Road Hendersonville NC 28792 Phone: 828-233-0848 Fax: 828-698-7714 Mon-Fri: 9 am- 5 pm, Sat & Sun: Closed (access to Asheville staff if needed)		
Thank you for your referral!			

For Office Use Only:

- ❖ Sona: AVL ___ HNDVL ___ Payment: COD __, CC ___
- ❖ Payment Information (please check one box): Check on Delivery Cash on Delivery
Credit Card: Card #: _____ Exp: _____ Card type: _____
- ❖ Packaging Options: All Medications in Bottles 7-day pill packs Bubble packaging Strip Packaging