# HIV REFERRAL FORM

Date:_____

**Y Medical Associates**
**Fax: 855-838-0623**
**Phone: 800-447-7558**

YMedical ASSOCIATES

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

## PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

## INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

## DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

**Primary Diagnosis**: ☐ B20 HIV ☐ B24 AIDS **Date of Diagnosis**: _____ **HIV/Hep-C Co-infection**: ☐ Yes ☐ No ☐ Unknown

**CD4 / TCELL Count**: _____ **HIV RNA**: _____ **HGB / HCT**: _____

**White Blood Cell Count**: _____ **Patient Weight**: _____ **Height**: _____ **Allergies**: _____

| MEDICATION | DOSE/STRENGTH | QUANTITY | REFILLS |
|---|---|---|---|
| **NRTI'S** | | | |
| ☐ Abacavir® | | | |
| ☐ Emtriva® | | | |
| ☐ Epivir® | | | |
| ☐ Retrovir® | | | |
| ☐ Videx® | | | |
| ☐ Viread® | | | |
| ☐ Zerit® | | | |
| ☐ Ziagen® | | | |
| **NNRTI'S** | | | |
| ☐ Edurant® | | | |
| ☐ Intelence® | | | |
| ☐ Rescriptor® | | | |
| ☐ Sustiva® | | | |
| ☐ Viramune® | | | |
| **Combo / ARV's** | | | |
| ☐ Atripla® | | | |
| ☐ Combivir® | | | |
| ☐ Descovy® | | | |
| ☐ Epzicom® | | | |
| ☐ Genvoya® | | | |
| ☐ Juluca® | | | |
| ☐ Odesfey® | | | |
| ☐ Triumeq® | | | |
| ☐ Trizivir® | | | |

| MEDICATION | DOSE/STRENGTH | QUANTITY | REFILLS |
|---|---|---|---|
| **Integrase Inhibitors** | | | |
| ☐ Isentress® | | | |
| ☐ Tivicay® | | | |
| ☐ Truvada® | | | |
| ☐ Vitekta® | | | |
| **Protease Inhibitors** | | | |
| ☐ Aptivus® | | | |
| ☐ Crixivan® | | | |
| ☐ Evotaz® | | | |
| ☐ Invirase® | | | |
| ☐ Kaletra® | | | |
| ☐ Lexiva® | | | |
| ☐ Prezcobix® | | | |
| ☐ Prezista® | | | |
| ☐ Reyataz® | | | |
| ☐ Viracept® | | | |
| **Entry Inhibitors** | | | |
| ☐ Fuzeon® | | | |
| ☐ Selzentry® | | | |
| **Boosting Agents** | | | |
| ☐ Norvir® | | | |
| ☐ Tybost® | | | |

**Other/Notes**:_____
_____

**Prescriber Signature:** _____ **DAW (Dispense as Written)** **Date:** _____