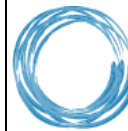


**UNIVERSAL REFERRAL FORM****Y Medical Associates****Fax: 855-838-0623****Phone: 800-447-7558****YMedical  
ASSOCIATES**

Date: \_\_\_\_\_

**PATIENT INFORMATION**
 Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Alternate 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: \_\_\_\_\_ Therapy:  New to Therapy  Currently on Therapy, Start Date: \_\_\_\_\_

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication	Form	Strength	Quantity	Dose	Refills	Directions

 Other/Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ DAW (Dispense as Written) Date: \_\_\_\_\_

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