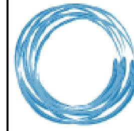
HIV REFERRAL FORM

Date:________________________________

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



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	MEDICATION	DOSE/STRENGTH	QUANTITY	REFILLS
NRTI'S				**Integrase Inhibitors**			
☐ Abacavir®	________	________	________	☐ Isentress®	________	________	________
☐ Emtriva®	________	________	________	☐ Tivicay®	________	________	________
☐ Epivir®	________	________	________	☐ Truvada®	________	________	________
☐ Retrovir®	________	________	________	☐ Vitekta®	________	________	________
☐ Videx®	________	________	________	**Protease Inhibitors**			
☐ Viread®	________	________	________	☐ Aptivus®	________	________	________
☐ Zerit®	________	________	________	☐ Crixivan®	________	________	________
☐ Ziagen®	________	________	________	☐ Evotaz®	________	________	________
NNRTI'S				☐ Invirase®	________	________	________
☐ Edurant®	________	________	________	☐ Kaletra®	________	________	________
☐ Intelence®	________	________	________	☐ Lexiva®	________	________	________
☐ Rescriptor®	________	________	________	☐ Prezcobix®	________	________	________
☐ Sustiva®	________	________	________	☐ Prezista®	________	________	________
☐ Viramune®	________	________	________	☐ Reyataz®	________	________	________
Combo / ARV's				☐ Viracept®	________	________	________
☐ Atripla®	________	________	________	**Entry Inhibitors**			
☐ Combivir®	________	________	________	☐ Fuzeon®	________	________	________
☐ Descovy®	________	________	________	☐ Selzentry®	________	________	________
☐ Epzicom®	________	________	________	**Boosting Agents**			
☐ Genvoya®	________	________	________	☐ Norvir®	________	________	________
☐ Juluca®	________	________	________	☐ Tybost®	________	________	________
☐ Odesfey®	________	________	________	**Other/Notes**: ________________________________			
☐ Triumeq®	________	________	________				
☐ Trizivir®	________	________	________				

Prescriber Signature: ________________________________ **DAW (Dispense as Written)** **Date**: ______________

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