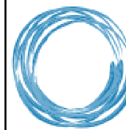
UNIVERSAL REFERRAL FORM

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: ______________________________________
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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