UNIVERSAL REFERRAL FORM	Y Medical Associates	
Date: ______________	Fax: 855-838-0623 Phone: 800-447-7558	

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: ____________________

Medication	Form	Strength	Quantity	Dose	Refills	Directions

Other/Notes:____________________

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

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