UNIVERSAL
• SPECIALTY PHARMACY •

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www.rxuniversal.com

General Referral Form

Urgent/Stat **Standard**

Prescriber

Prescriber Information

Prescriber Name:				MD PA NP
NPI:		DEA:		Office Contact:
Address:				
City:	State:	Zip:	Phone #:	Fax #:

Patient

Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards

First Name:		MI:		Last Name:
DOB:	Sex: M F	Last 4 Digits SSN :		Interpreter: Y N Specify:
Address:				
City:	State:	Zip:	Primary #:	Alternate #:
Emergency Contact:		Phone #:		Contact Preference: AM Noon PM

Clinical

Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents

Primary ICD10:		Secondary ICD10:	Diagnosis Date: / /
Weight: lb/ kg	Height: in/ cm	Allergies:	
Current Medications:			
Prior Therapies:			
Continuity of Care: / /			

Prescription

Prescription Information

Dose Start Date: / /	New Prescription	Refill Prescription	New to Therapy	Restarting Therapy
Deliver to:	Patient's Home	Prescriber's Office	Other	

Medication	Strength	Quantity	Directions	Refills

Dispense ancillary supplies, syringes and medical equipment necessary to administer medication.

By signing this form and utilizing our services, you are authorizing Universal Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Sign

Prescriber Signature and Date (Required to validate prescription)

Physician Signature:	Date: / /

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