State University of New York

Upstate Medical University

Universal Patient Referral Form

MD Direct: 1-800-544-1605

Patient Information

Legal Name of Patient (last, first, middle initial):

_____

Sex: _____ Female _____ Male

Birth date:_____

Telephone #: Home ( ) _____ Office ( ) _____ Other ( )_____

Insurance Carrier: _____

Authorization Needed? _____Yes _____No Authorization #_____

Was patient previously seen at University Hospital and/or Clinics? _____Yes _____No

If minor, parent or guardian (last, first, middle initial):

_____

Address (street, town, state, zip):

_____

Reason for Referral: _____

Special Symptoms: _____

Diagnostic Tests Performed/Results: _____

_____

List of Current Medications and Dosages:

_____

_____

_____

_____

_____

_____

_____

Other: _____

_____

_____

_____

Referring Physician: _____M.D.

Address (street, town, state, zip)_____

_____

Telephone (area code, number): _____ Fax: _____

Please return completed form to:

FAX: 315-464-6880

SUNY Upstate Medical University/MD Direct

750 East Adams Street

Syracuse, NY 13210.