

Specialty Service Referral Infectious Disease

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REFERRING PROVIDER

Name _____ Phone _____ Fax _____

Reason for Referral _____

_____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related ☐ Yes ☐ No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

INFORMATION NEEDED

Please include all the information below.

- ☐ Provider Notes
- ☐ Procedure Reports
- ☐ Appropriate Laboratory Reports
- ☐ Appropriate Imaging Reports
- ☐ Medication and Allergy Lists

Please indicate specialty needed for referral.

Preferred Provider

Appointment Urgency

- ☐ First available
- ☐ Urgent

REFERRING RESPONSE

- ☐ Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

- ☐ Patient NOT Scheduled

Additional Information Required _____

Other Reason _____