Infectious Disease Specialists
of North Alabama

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REFERRAL REQUEST

DATE: _____

REFERRING DOCTOR: _____

SPECIALTY: _____ **NPI:** _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

REASON FOR CONSULTATION: _____

PATIENT INFORMATION

NAME: _____DOB:_____

ADDRESS: _____

PHONE: _____

PLEASE NOTE

APPOINTMENT WILL NOT BE MADE UNTIL THE FOLLOWING HAS BEEN RECEIVED BY OUR OFFICE:

- PATIENT DEMOGRAPHICS
- INSURANCE REFERRAL IF REQUIRED (MEDICAID PT 1ST, HEALTHSPRINGS, TRICARE PRIME ETC)
- OFFICE NOTES
- LAB SEROLOGY TO INCLUDE CULTURES, CBC, CMP, BMP, ESR, CR, ETC
- RADIOLOGY
- PATHOLOGY

ONCE ALL REQUIRED INFORMATION IS RECEIVED, WE WILL SCHEDULE THE APPOINTMENT AND FAX THIS FORM BACK TO YOU. **YOU WILL NEED TO NOTIFY THE PATIENT OF THIS APPOINTMENT**. WE WILL MAIL PAPERWORK TO THE PATIENT TO BE COMPLETED PRIOR TO APPOINTMENT.

THE ABOVE REFERENCED PATIENT HAS BEEN SCHEDULED TO SEE

DR. PARKER ON _____ AT _____