

**Infectious Diseases Consultants Group, PC**

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**Referral Form**

Date:

Referring Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

How did you hear about us?

**Patient Information:**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address:

Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #:

Referral # (if any):

**Referral for Consultation:**

Diagnosis:

\_\_\_\_\_

—

\_\_\_\_\_

—

Pertinent History:

\_\_\_\_\_

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\_\_\_\_\_

—

List of Current Medication:

\_\_\_\_\_

Form Completed By: \_\_\_\_\_

Date:

\_\_\_\_\_