

Raleigh Infectious Diseases Associates
Request for Office Consultation
 Phone 919-571-1567 Fax 919-782-1472

Due to an increasing number of requests for consults and an inability to accommodate them all, we regret that we are unable to schedule patients for evaluation of the problems listed below. If you have a patient with one of the listed conditions whom you believe needs to be seen, please have a physician contact us directly.

- | | |
|--------------------------------|---------------------------------------|
| Chronic Fatigue | Chronic yeast infections |
| Chronic Sinusitis | Evaluation of CMV, EBV or RMSF titers |
| Lyme Disease | MRSA skin infections |
| Positive tuberculin skin tests | Recurrent Urinary Tract Infections |

Please provide the following:

- Copy of Insurance Card and Preauthorization if needed.
- Minimum one year of records to include: office notes, labs, radiology reports, hospital records.

Date _____ Reason for Consult _____

Notify Patient Office Other of appointment time.
 Name _____ Phone _____

Patient Information

Name _____
 Date of Birth _____ Social Security # _____
 Address _____
 City _____ State _____ Zip _____
 Phone #'s:
 Home _____ Work _____ Other _____
 Referring MD: _____ Phone _____
 Address _____
 City _____ Zip _____
 NPI _____
 Office Contact Person _____ Fax _____
 Name of other medical provider(s) involved in the care of patient _____

Patient Insurance Information (if not previously provided)

Insurance Company: _____
 HMO?
 If yes, authorization # _____ Primary MD _____
 Workers Comp? Contact Person _____ Phone _____
 Address _____ Case# _____
 Other? _____

Comments: _____

For office (RID) use only:

Patient Medical Records received Date _____ Time _____
 Reviewed/Approved by MD _____ Date _____
 1st Appointment: Date _____ Time _____
 2nd Appointment: Date _____ Time _____

<input type="checkbox"/> New Patient Information Mailed
<input type="checkbox"/> Appointment Confirmed by _____
Date _____