Raleigh Infectious Diseases Associates
Request for Office Consultation

Phone 919-571-1567 Fax 919-782-1472

Please fax the following information including:

- **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 date/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 _____ NC HIE/Direct Connect email _____
Office Contact Person_____ Fax_____
Name of other medical provider(s) involved in the care of patient_____
_____

Patient Insurance Information

Insurance Company: _____
☐ Is a pre-aquthorization required?
If yes, authorization # _____ Primary MD _____
☐ Workers Comp? Contact Person _____ Phone_____
Date of Injury _____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*_____

☐ New Patient Information Mailed
☐ Appointment Confirmed by _____
Date _____