ID CARE®
INFECTIOUS DISEASES SPECIALTY PRACTICE
1319 AVON STREET
FAYETTEVILLE NC 28304
P 910.729.6552
F 910.500.1002

ID CARE® REFERRAL REQUEST FORM

REFERRING TO

SPECIALTY: INFECTIOUS DISEASES	**PHONE:** 910.729.6552	**FAX:** 910.500.1002
PRACTICE ADDRESS: 1319 AVON STREET FAYETTEVILLE NC 28304		

PLEASE SCHEDULE :

URGENT : _____

ROUTINE APPOINTMENT WITH : V SAVALIYA, MD / M LEWIS, DO / E ONYEASO, MD

FIRST AVAILABLE WITH ANY PHYSICIAN : _____

REFERRING PROVIDER'S NAME:	**PHONE:**	**FAX:**

REASON FOR REFERRAL

REASON FOR REFERRAL

PATIENT INFORMATION

PATIENT FULL LEGAL NAME:		DOB
IF PATIENT IS UNDER 18 YEARS OLD – PARENT CONTACT NAME:		
PREFERRED PHONE:	BEST TIME TO CALL:	
SPECIAL PATIENT CONSIDERATIONS:		
PATIENT INSURANCE INFORMATION:		
PATIENT'S PRIMARY CARE PROVIDER:	PHONE:	FAX:

GENERAL INFORMATION

CLINICAL QUESTION:

COMMENTS/CONSIDERATIONS RELATED TO CLINICAL QUESTION: **PLEASE INCLUDE RECENT OFFICE NOTES, LABS, PERTINENT IMAGING REPORTS, MEDICATION LIST, PROBLEM LIST, ALLERGIES, AND RELEVANT CLINICAL INFORMATION.**

PATIENT AWARE OF REASON FOR REFERRAL? YES NO: EXPLAIN

PROVIDER REFERRAL CONFIRMATION

REFERRAL CONFIRMATION

REFERRAL ACCEPTED? YES NO: EXPLAIN

APPOINTMENT SCHEDULED WITH:	**DATE & TIME:**
PATIENT REFUSED SCHEDULING	PATIENT PREFERS TO CONTACT SPECIALIST TO SCHEDULE AT A LATER DATE

REQUEST FOR ADDITIONAL SUPPORTING CLINICAL INFORMATION (PLEASE DETAIL):

PERSON COMPLETING CONFIRMATION:	**DATE OF CONFIRMATION:**