Infectious Diseases Associates
OF NORTH CENTRAL FLORIDA

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REFERRAL FORM

Date: _____ **NP1#:** _____

Referral from Dr: _____ **Phone:** _____ **Fax:** _____

Patient Name: _____ **Phone #:** _____

DOB: _____ **Social Security #:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Insurance: _____ **ID #:** _____

Secondary Insurance: _____ **ID #:** _____

Please Check: ☐ **Next Available** ☐ **As Soon As Possible** ☐ **Urgent**

Reason for Referral: _____

_____

_____

_____

_____

OFFICE USE ONLY:

_____Requesting Additional Records: _____

_____Need Insurance Authorization Number: _____

Appointment Scheduled on: _____

_____Patient Notified

_____Unable to Contact Patient _____Patient Declined Consultation

_____No Show for Referral _____Left Message