



Infectious Disease Associates of North Central Florida  
3306 SW 26<sup>th</sup> Ave Suite 104, Ocala, FL 34471  
P: 352-622-2020  
F: 352-622-2025

## Referral Form

### Referring Physician Information

Date: \_\_\_\_\_ Appointment Needed: \_\_\_\_\_STAT \_\_\_\_\_ASAP \_\_\_\_\_First Available

Referring Physician's Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

### Patient Information

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

DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_

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### Requested Appointment

Reason for Referral:

\_\_\_\_\_  
\_\_\_\_\_

### Medical Records Sent w/ Referral:

- \_\_\_\_\_ Demographics w/ Insurance
- \_\_\_\_\_ Office Notes, H&P, DC Summary, OP Notes
- \_\_\_\_\_ Current Labs & Imaging

Thank you for allowing us to participate in caring for your patient.  
We will contact the patient within 48 hours of receipt of this referral.