

**Regional Center for Infectious Disease**

[**www.conehealth-rcid.com**](http://www.conehealth-rcid.com)

**301 E. Wendover Medical Center, Suite 111**

**Greensboro, NC 27401-1209**

**Telephone # : 336-832-7840**

**Fax #: 336-832-3285 or 336-832-8881**

**PATIENT REFERRAL**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_\_\_\_\_\_\_Male \_\_\_\_\_\_\_\_\_\_Female

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient aware of reason for referral? \_\_\_\_\_\_Yes \_\_\_\_\_\_ No: Explain

**OFFICE USE ONLY**

Appointment Date/Time: \_\_\_\_\_\_\_\_\_\_ID Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE FOLLOWING RECORDS ARE NECESSARY**

Comments/ Considerations Related to Clinical Questions: \*\* Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes. Copy of patient’s insurance card. HIV referrals require copy of Eliza / Western Blot results, vaccine history. Appointment will be made after receiving requested information and records. Please complete all information.