UAB Infectious Diseases
Referral Request Form

1900 University Blvd
Suite THT 229
Birmingham, AL 35294

Phone: 205-934-5191
Fax: 205-934-5155

DATE: ________________

REFERRING DOCTOR: ____

SPECIALTY: ______________________ **NPI:** ______________________

ADDRESS: ____

PHONE: ______________________ **FAX:** ______________________

REASON FOR CONSULTATION: ________________________________

PATIENT INFORMATION

NAME: ____ DOB:__________

ADDRESS: ____

PHONE: ______________________

PLEASE NOTE

APPOINTMENT WILL NOT BE MADE UNTIL THE FOLLOWING HAS BEEN RECEIVED BY OUR OFFICE:

- PATIENT DEMOGRAPHICS
- INSURANCE REFERRAL IF REQUIRED (MEDICAID PT 1ST, HEALTHSPRINGS, TRICARE PRIME ETC.)
- OFFICE NOTES
- HOSPITAL RECORDS (IF AVAILABLE)
- LAB SEROLOGY TO INCLUDE CULTURES, CBC, CMP, BMP, ESR, CR, ETC.
- RADIOLOGY
- PATHOLOGY

ONCE ALL REQUIRED INFORMATION IS RECEIVED, WE WILL SCHEDULE THE APPOINTMENT AND NOTIFY THE PATIENT OF THIS APPOINTMENT. WE WILL MAIL PAPERWORK TO THE PATIENT TO BE COMPLETED PRIOR TO APPOINTMENT.