UAB HOSPITAL-HIGHLANDS INFECTIOUS DISEASE NEW PATIENT REFERRAL FORM

PATIENT INFORMATION:

NAME: Last _____ First _____ MI _____

ADDRESS: _____ APARTMENT/UNIT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ CELL PHONE: _____ EMAIL: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

INSURANCE NAME & CONTRACT NUMBER: _____

REASON FOR REFERRAL: _____

Attach all records including notes, lab results (microbiology, pathology, & susceptibilities), imaging reports, and actual images (CD disc/push images via PACs). Failure to provide supporting documentation will delay records review. All records are reviewed before determining whether an appointment will be made.

REFERRING PHYSICIAN INFORMATION:

PROVIDER NAME: _____ PROVIDER NPI: _____

ADDRESS: _____

PHONE NUMBER: _____FAX NUMBER: _____

FAX INFORMATION:

- Please fax the records supporting the reason for referral. Include relevant notes, lab results, and imaging reports/actual images as outlined above.
- Please include all records mentioned above, so that an appointment can be made in a timely manner.
- Fax this referral form and supporting documentation to: **205-930-8275**

For questions, please call 205-930-8310