WakeMed
Infectious Diseases

Phone: 919-235-1802
Fax: 919-235-1354

REQUEST FOR CONSULTATION

Please fax the following information including:

- **Copy of Insurance Card and Preauthorization if needed.**
- **Minimum one year of records to include: office notes, labs, radiology reports, hospital records.**

CONSULT INFORMATION

Date: _____ Reason for Consult: _____

Notify: ☐ Patient ☐ Office ☐ Other: Name: _____ Phone: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City/State/Zip: _____

Phone #'s: Home: _____ Work: _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

NPI _____ NC HIE/Direct Connect email: _____

Office Contact Person: _____ Fax: _____

Name of other medical provider(s) involved in the care of patient _____

_____

PATIENT INSURANCE INFORMATION

Insurance Company: _____

☐ Is a pre-authorization required? ☐ Yes ☐ No

If yes, authorization # _____ Primary MD: _____

☐ Workers Comp? Contact Person: _____ Phone: _____

Date of Injury: _____ Address: _____ Case#: _____

☐ Other? _____

_____

Comments: _____

_____

_____

For office (WMID) use only:

Patient Medical Records received: Date _____ *Time* _____

Reviewed/Approved by MD _____ *Date* _____

1st Appointment: Date _____ *Time* _____

2nd Appointment: Date _____ *Time* _____

☐ New Patient Information Mailed

☐ Appointment Confirmed by

_____

Date _____

Thank you for referring your patient to WakeMed – Infectious Diseases