Infectious Diseases
Arnold Palmer Hospital for Children

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PEDIATRIC INFECTIOUS DISEASES
REFERRAL DATA SHEET

PATIENT'S NAME: ______________________________ **DATE:** ________________

D.O.B.: ____________________ **AGE** ____________ **PHONE:** ________________

P.C.P.: ______________________________________ **PHONE:** ________________

REFERRED BY: _________________________________ **PHONE:** ________________

INSURANCE: ____

DIAGNOSIS: ____

REASON FOR CONSULTATION: ____

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PLEASE INCLUDE A BRIEF CLINICAL SUMMARY AND ENCLOSE LABORATORY/ANCILLARY TESTS PERFORMED

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CHECKLIST:

❑ Primary Insurance Clearance

Visits______________ Auth #:_____________________ Exp:____________ Co-pay:_______

❑ Secondary Insurance Clearance

Visits______________ Auth #:_____________________ Exp:____________ Co-pay:_______

❑ Appointment set for __________________________ ❑ Opened account with Pre-Registration