Wilmington Health

Infectious Diseases & Travel Clinic

Referral Request

Thank you for referring your patient to Wilmington Health Infectious Diseases & Travel Clinic for evaluation and treatment. Please fax all related medical records and insurance cards along with this form.

Patient Name: _____ SSN: _____ Sex: _____

DOB: ___/___/____ Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Insurance Company: _____ Authorization Number: _____

Referring Physician: _____ Phone: ( ) _____

Fax: ( ) _____

Reason for Referral: _____

Urgency of Request (please check one)

- ☐ 1-2 weeks
- ☐ Other (please specify) _____
- ☐ First available

Medical records pertaining to this problem must be sent with referral form. PLEASE include any labs, X-rays, or CULTURES that will help us in evaluating this problem for your patient.
Do you want us to contact the patient or call your office?_____

We appreciate the referral. If we can be of additional service or if you have questions or concerns, please call 910.341.3426. If you run out of referral forms, you can download additional forms at http://www.wilmingtonhealth.com/referring-physicians.

FOR INTERNAL USE

Wilmington Health will fax this form back to your office once an appointment has been confirmed.

Confirmation: Your patient was contacted and an appointment was confirmed.

Date: ___/___/____ **Time**: ____:____ (AM/PM)

Wilmington Health Infectious Diseases & Travel Clinic
1202 Medical Center Drive
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Phone: 910.341.3426
Fax: 910.251.2174
wilmingtonhealth.com