

PLEASE DIRECT PATIENTS TO OUR
WEBSITE TO FILL OUT
PAPERWORK. IF THEY ARE
UNABLE TO ACCESS, TELL THEM
TO COME 10 MINUTES EARLY TO
FILL IT OUT IN THE OFFICE
(www.alabamaidc.com)

ALABAMA INFECTIOUS DISEASE CENTER, P.C.

420 LOWELL DRIVE, SUITE 301
HUNTSVILLE, AL 35802
PHONE: 256-265-7955 FAX: 256-265-7954 OR 256-265-4017

PHYSICIAN REFERRAL FORM

DATE: _____ SPOKE WITH: _____
REFERRING PHYSICIAN: _____ NPI: _____
PHYSICIAN PHONE#: _____ FAX#: _____
DIRECT MESSAGING EMAIL: _____

PATIENT'S NAME: _____ (M/F)

DOB: _____ SSN: _____ ADULT: _____ CHILD: _____

PATIENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT'S PHONE #: _____ CELL PHONE #: _____

PRIMARY INSURANCE: _____ POLICY #: _____

GROUP#: _____ INSURANCE REFERRAL REQUIRED?: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

SECONDARY INSURANCE: _____ POLICY #: _____

GROUP #: _____ INSURANCE REFERRAL REQUIRED?: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

REASON FOR CONSULT: _____

HASSOUN _____ SIDDIQUI _____ CHAUDHRY _____ AL KHOURI _____

DATE OF APPOINTMENT: _____ TIME: _____ SCHEDULED BY: _____

DOCTOR'S REQUESTING CONSULT (SIGNATURE): _____

PLEASE FAX ALL PERTINENT MEDICAL RECORDS AND DEMOGRAPHIC INFORMATION. THANK YOU FOR THE
CONSULT.

ELECTRONIC FAX (256-265-7954) OR MANUAL FAX (256-265-4017)