LEXINGTON INFECTIOUS DISEASE CONSULTANTS

Request for Consultation

For LIDC office use only:

Scheduled: _____

If scheduled the patient has been called and paperwork has been mailed. Please call with any questions.

Requesting Physician: _____ **Contact Person**: _____

Address:_____

Phone: _____ **Fax:** _____ **NPI:** _____

Patient Name | **Date of Birth** | **Social Security #**

Street Address | **City, State, Zip**

(Home) Phone # | **(Cell) Phone #** | **(Work) Phone #**

Insurance | **ID#**

Reason for Referral

Incomplete forms will be returned

_____

(Please include records for review (Notes, Labs, Cultures, and Radiology Reports)

Does the patient have Diabetes? ____ Type:____ Peripheral Vascular Disease?____ Neuropathy?____

Does the patient have Chronic Kidney Disease? _____ Stage: _____

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