

Infectious Disease Associates of Syracuse
725 Irving Ave., Suite 311
Syracuse, NY 13210
315-464-9360
315-464-9361 Fax

CONSULTATION REQUEST FORM

Return this form with demographic info, notes, labs, testing reports to
Fax 315-464-9361

Patient _____ DOB _____

Diagnosis _____

The Requesting Physician asks that Infectious Disease Associates provide an opinion and consult for the above named patient. This patient is being sent to Infectious Disease Associates for the following reasons:

Reason for consult _____

Hospital _____ Date of Discharge _____

Requesting MD _____

Phone _____ Fax _____

Contact person _____

Address _____

Requesting Physician signature _____

FOR OFFICE USE ONLY

Additional information requested: Date _____

Labs _____

Radiology _____

H&P _____

Misc info from ID Attending/Fellow _____

Approved by ID Attending _____

Schedule patient in _____ weeks

Appointment _____

Requesting Office Notified of Appt. & will notify patient.