

**REQUEST FOR CONSULT/REFERRAL FROM
THE PEDIATRIC INFECTIOUS DISEASES CLINIC
LEVINE CHILDREN'S HOSPITAL @ CAROLINAS MEDICAL CENTER**

AMINA AHMED, MD

DAVID RUPAR, MD

PATIENT INFORMATION

Name: _____ DOB: _____

Reason for referral: _____

History: _____

Other significant medical history:

Current medications:

Other specialists involved in this child's care:

Please include:

- Office notes
- Lab/radiology
- Growth charts
- Immunization records
- Notes from other specialists

REFERRING PROVIDER INFORMATION

Physician's Name: _____

Practice: _____ Phone: _____ Fax: _____

Best way to contact you? _____

Do you prefer: written note only
 telephone call plus note

Please fax to: Tomeco Murray, LCSC Medical Records Coordinator, Fax#: 704-381-8836

Thank you for referring this patient to us.

(Appt. Date & Time: «AptDate»)