Request for Washington University Infectious Disease Consultation

Washington University in St.Louis
SCHOOL OF MEDICINE

Street location: 620 S. Taylor Ave, suite 100, St. Louis, MO 63110
Mailing address: 4523 Clayton Ave, campus box 8051, St. Louis, MO 63110

Thank you for your referral to our ID practice. To expedite scheduling of your patient's appointment, **please complete this form and fax it with pertinent medical records to FAX 888-869-4437**.

Pertinent medical records include:

- History & Physical, office notes, and lab results; radiology reports when applicable.
- HIV referrals must have a recent CD4 and viral load **OR** a confirmed (+) HIV test result.

For information regarding our providers, go to http://id.wustl.edu/
For information about our HIV program, go to http://hiv.wustl.edu/

We have a limited number of new patient appointments. Records will be reviewed for appropriateness of referral. If we are unable to meet your patient's needs, we will advise your office within 3 working days. Scheduled appointments will be made based on the first availability.

REFERRING PROVIDER INFORMATION:

Referral Date: ___________________ Referring MD/Provider or Agency: ______________________________

Referring Office Contact Person or Case Manager: ____

Phone #: _(________)____________________________ Fax #: _(________)______________________________

Diagnosis & Reason for Infectious Disease Referral: ____

____ Is this a new diagnosis? ___________

Request for a Specific WU ID Provider (please indicate name)____

PATIENT INFORMATION:

Patient Name: ____

DOB: ___________________________________ SSN#: ____

Phone #: ________________________________ Alternate Phone #: ___________________________________

Address: ____

City/State/Zip: ____

Insurance: (please include copies front & back of cards): ____

If Ryan White eligible, indicate patient's DCN:____

If patient is a non-English speaker, indicate primary language spoken: __________________________________