UCSF Health Infectious Diseases (ID) Clinic

NEW PATIENT REFERRAL/CONSULTATION FORM

Instructions: Please select the reason for referral and provide the requested information for the selected referral indication. Note that we cannot schedule an appointment until all requested information is received.

Non-Accepted Referrals:

Following referrals are not accepted	Following referrals should be redirected
Chronic fatigue syndrome Chronic Lyme disease Delusional parasitosis Morgellons's disease Post COVID syndrome (Long COVID)	Hepatitis B/C (→Hepatology Clinic) HIV Care/PEP or PrEP (→HIV Clinic) Pediatric patient (→Pediatric ID) Travel Vaccination (→Travel Clinic: https://www.sf.gov/location/aitc-immunization-travel-clinic)

PATIENT DEMOGRAPHICS	**Name of patient:** _____ **DOB:** _____ **Interpreter needed:** Yes ☐ No ☐ **Language (if interpreter needed):** _____ **Home phone:** _____ **Work or Cell Phone:** _____ **Address:** _____ **City:** _____ **Zip:** _____
INSURANCE COVERAGE INFORMATION	**Payor/Plan Name:** _____ **Member ID:** _____ **Payor/Plan Phone:** _____ **Group Name/ID:** _____ **Claims Address:** _____ **Include patient's insurance card (both sides) and HMO authorization if required.**
PRIMARY CARE PROVIDER INFORMATION	**PCP Name:** _____ **Phone:** _____ **Referring MD:** _____ **Specialty:** _____ **Phone:** _____ **Fax:** _____

ADDITIONAL INFORMATION	**Does the patient need a transplant ID specialist (pre/post solid organ transplant or stem cell transplant/hematology malignancy)?** Yes ☐. No ☐ **Please include the following information with this form:** 1. Last 2 medical notes related to referral 2. Microbiology, Pathology, Laboratory information related to diagnosis 3. Radiology reports: Image studies (report and actual images) last 3 months related to diagnosis
REASON FOR REFERRAL (Please circle or specify)	☐ Abnormal serology/labs ☐ Central nervous system infection (Brain abscess, Meningitis, Encephalitis) ☐ Cryptococcal meningitis ☐ Diabetic foot infection (including osteomyelitis) ☐ Endovascular infection (Bacteremia, Endocarditis, LVAD, CIED infection) ☐ Fungal infection (Coccidioidomycosis, Aspergillosis, Mucormycosis) ☐ Fever of unknown origin ☐ Gastrointestinal infection (C diff, H pylori, Diarrhea, Intrabdominal abscess, Liver abscess) ☐ Latent tuberculosis ☐ Lyme disease ☐ Malaria ☐ Neurocysticercosis ☐ Neurosyphilis ☐ Non-tuberculosis mycobacteria (NTM) ☐ Osteomyelitis ☐ Parasite infection ☐ Pretransplant infectious disease evaluation ☐ Prosthetic joint infection/ Spinal hardware infection ☐ Pulmonary nodule ☐ Septic arthritis ☐ Sexually transmitted disease ☐ Skin and soft tissue infection (Cellulitis, Breast Implant infection) ☐ Syphilis ☐ Tuberculosis ☐ Urinary tract infections ☐ Vertebral osteomyelitis ☐ Viral infection (CMV, HSV, VZV) ☐ Other: _____ _____

Please fill out this form completely and submit it with the required documentation to ensure timely processing of your referral. Referrals missing information or for non-accepted conditions will be returned to the ordering provider. Thank you for your cooperation.