CSBS/HIDC REFERRAL FORM

Health and Infectious Disease Care (HIDC)
A DBA of Cadet's Solutions

Address: 1900 Hillcrest Street, Orlando, Florida 32803
Phone: (407) 917-0853 | Fax: (407) 641-8591

I. **Referring Provider Information**

Referring Provider/Physician: _____
Med.Office:_____
Phone:_____
Fax:_____
NPI:_____
Date:_____

II. **Patient Information**
Name:_____
DOB:_____Gender:_____Phone/
Email:_____
Insurance:_____
Member ID:_____
Group #: _____
(Please attach a copy of the patient's insurance card)

III. **Clinical Information**
Reason for Referral / Diagnosis:
_____

Relevant Medical History:
_____

Current Medications:
_____
_____

IV. Requested Services
☐ Infectious Disease Consultation
☐ HIV/AIDS Care
☐ Travel Medicine
☐ STI Screening/Treatment
☐ Other: _____

Urgency: ☐ Routine ☐ Urgent (Please call office for same-day/next-day availability and info needed for pre-authorization)

Please fax this completed form along with the patient's recent progress notes, lab and imaging results, and insurance information to (407) 641-8591.