UB|MD PEDIATRICS

NEW PATIENT REFERRAL FORM

Please complete the following and fax to the Division of Infectious Diseases at 716.323.0296.

Patient Name: _____ DOB: _____/_____/_____

Referring Provider: _____

PMD (if different than above): _____

Phone: _____ Fax: _____

Reason for Visit:

- ☐ LYME DISEASE
- ☐ MRSA/MSSA
- ☐ OSTEOMYELITIS
- ☐ FEVER
- ☐ FUNGAL INFECTION
- ☐ KAWASAKI
- ☐ IMPETIGO
- ☐ SCABIES
- ☐ WORM INFECTION
- ☐ TOXOPLASMOSIS
- ☐ HEPATITIS
- ☐ CMV
- ☐ HIV
- ☐ HERPES
- ☐ MONO
- ☐ MALARIA
- ☐ CELLULITIS
- ☐ HAND, FOOT & MOUTH
- ☐ OTHER (SPECIFY):

_____

Other Physician(s)/Facilities Involved in Care of Patient:

Additional Comments:

If you need to reach our office, please call 716.323.0150. Thank you for your referral.

Division of Infectious Diseases
1001 Main Street, 5th Floor | Buffalo, NY 14203 | T: 716.323.0150 | F: 716.323.0296 | UBMDPediatrics.com