

**NEW PATIENT REFERRAL TO**

**Robert G. Penn, MD**  
**Infectious Diseases Associates, PC**  
8111 Dodge ST, STE 363  
Omaha, NE 68114

**FAX TO: 402.934.6518**

**Include Copies of All Patient's:**

**Labs      Test Results      Charts**

(Diagnostic testing, culture results, office notes, and demographic sheet)

**REFERRAL FROM:**

**REFERRING PHYSICIAN**

Name \_\_\_\_\_

Group \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

**PATIENT:**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phones: \_\_\_\_\_

\_\_\_\_\_

**DATE:** \_\_\_\_\_

**REASON FOR REFERRAL:**

**Patient should call Dr. Penn's office for an appointment at 402.934.6504,  
after this form and attachments are faxed unless other arrangements are made.**