

**The Johns Hopkins Ambulatory
TROPICAL MEDICINE
Consultation Service**

Dear Primary Health Care Provider:

Date: __/__/__

The Johns Hopkins Ambulatory Tropical Medicine Consultation Service sees patients who have RETURNED after travel to places outside of the United States, usually to low income areas, and who have illnesses that may be related to that travel. Our service may not be the right location for the diagnostic dilemma facing you and your patient. Therefore, to insure that we are the most appropriate specialty for your patient, please provide the information requested below. After review, we will contact you to either schedule an appointment for your patient or suggest a more appropriate specialist.

1. Name of the PRIMARY CARE PROVIDER referring the patient. We only accept referrals through a PCP: _____ Professional Credential: MD/DO NP

Office Phone: _____ Address: _____

2. What is the question that you wish to have answered about this patient?

3. Countries of travel and dates of travel:

Country of Travel	Start Date	End Date

4. Please submit the following for review

- a. All office visit notes from all providers who have seen and evaluated this patient for the problem for which you are seeking consultation
- b. All laboratory result reports from evaluations of this patient's current problem
- c. All imaging studies relating to the current condition
- d. All results of procedures carried out when investigating this condition

5. Patient Name (PRINT): _____ Date of Birth: _____

After receipt of all requested information and this completed form, you will be contacted within 3 working days.

Sincerely,

Shone Sterner, Clinical Program Coordinator