**Allergy & Asthma Centers**
**Helping patients with allergic disorders to enjoy life**

# Physician Referral Form

Appointment Type: Consult--- Consult and Treat--- Consult and Ongoing Care--- Other---
**Reason for Referral**_____
Any Testing Performed: Type_____
Patient record in Athena__Y/N_

| | | |
|---|---|---|
| **Patient Name**: | | |
| **Date of Birth:** | | Sex: M F |
| Home Address: | | |
| City: | State: | Zip Code: |
| Home Phone: | Cell Phone: | Work Phone: |
| Email Address: | | |
| **Insurance Information**: | Copy of Insurance Card Attached__Y/N__ | |
| Guarantor Name: | Date of Birth: | |
| Insurance Provider: | | |
| ID Number: | Group Number: | |
| Does the patient need an interpreter? Yes No Language Needed | | |
| **Referring Physician**: | **Contact Person**: | |
| Office Phone: | Office Fax: | |
| Preferred Method of Communication: Office__ | Cell Phone__Athena Message__(if applicable) | |
| Office Address: | | |
| Primary Physician: (*if different than referring)* | | |
| **Carmel Allergy will fax back**: Appointment Date and Time: | | |
| Physician: | | |
| NPI: | | |
| Location: | | |
| Please send the following clinical information: ---Labs (6mo-1yr.) --- Imaging --- Office Notes (1yr.) --- Other_____ | | |

***If you do not receive confirmation of an appointment within 24 Hours, please contact our office Tel: 317 795 0707 Fax 317 795 0706***

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