# *Allergy & Asthma Consultants of Mid-Michigan, P.C.*

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## PATIENT REFERRAL FORM

Please complete the following and fax to **(517) 393-4202**

### PATIENT INFORMATION

Name: _____ Parent Name (if under 18) _____
Address: _____ DOB: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____

**INSURANCE CARRIER** – Please fill out all insurance information. (Please enclose copy)

Primary _____ Secondary _____
Contract # _____ Contract # _____
Group # _____ Group # _____

### REFERRING PHYSICIAN INFORMATION

Referring Physician _____ Office Contact _____
Phone: _____ Fax: _____
Address: _____
Reason for Referral: _____
Appointment Date: _____ Time: _____

*Please provide billing numbers requested below.
UPIN _____ Tax ID _____
NPI _____ Medicaid _____
State License _____

Thank you for your referral.

**Specialize in:**

**Allergic Rhinitis**
**Anaphylaxis**
**Asthma**
**Atopic Dermatitis/ Eczema**
**Drug Allergy**
**Food Allergy**
**Insect Sting Allergy**
**Sinusitis**
**Urticaria/Angioedema**
**Immunodeficiency**
**Latex Allergy**

**Services:**

**Consultation**
**Scratch Testing**
**Intradermal Testing**
**Patch Testing**
**Allergy Injections (Immunotherapy)**
**Venom Testing**
**Pulmonary Function Testing**