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/Cell Phone: _____Work 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 for provider requested below.**
UPIN _____ Tax ID _____
NPI _____Medicaid _____
State License_____

Specializing in:
Allergic Rhinitis
Anaphylaxis
Asthma
Atopic Dermatitis/Eczema
Drug Allergy
Food Allergy
Insect Sting Allergy
Sinusitis
Urticaria/Angiodema
Immunodeficiency
Latex Allergy

Services offered:
Consultation
Scratch Testing
Intradermal Testing
Patch Testing
Allergy Injections (Immunotherapy)
Venom Testing
Pulmonary Testing

Thank you for your referral.