Allergy & Asthma Clinic of San Antonio

Adult & Pediatric

www.allergyasthmasa.com

PATIENT REFERRAL FORM

To: Scheduling Fax: **(210) 692-9486** *or* Email: contact@allergyasthmasa.com

From: ____

Patient Information

Patient Name: ____ DOB: __________________

Insurance: ______________________________________ Insurance ID:_________________

Insurance Phone Number: __________________ Social Security #: __________________

DX: ____

Please include authorization for the following procedures: Office Visit, Allergy Skin Test, Allergy Extract, Venom Extract, Allergy and Venom Injections, Semi-Rush Therapy and Spirometry

Information Required with this Referral

►Patient Demographics ►Copy of Insurance Card ►Medication List

►Most Recent Diagnostics Study Reports ►Last Office Note

►Physician NPI# __________________ ►Referral #__________________

►Number of visits authorized ________ ►Referral Exp. Date __________________

Physician Signature: ____________________________________ Date: _______________

2829 Babcock Road, Suite 115
San Antonio, Texas 78229

Form Revised: 07/2014

Phone: (210) 692-9555
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