ALABAMA ALLERGY & ASTHMA CENTER™

# FAX REFERRAL FORM

PLEASE FAX THIS FORM TO
**205.449.6101**

DATE: _____

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

PARENT/LEGAL GUARDIAN: _____

CONTACT PHONE NUMBER: _____

ALTERNATE PHONE NUMBER: _____

PATIENT INSURANCE: _____

REASON FOR REFERRAL OR CONSULT: _____

_____

AAAC PROVIDER REQUEST:
[ ] Weily Soong, MD
[ ] Maxcie Sikora, MD
[ ] John Anderson, MD
[ ] Sunena Argo, MD
[ ] William Massey, MD
[ ] Carolyn Comer, MD
[ ] Njeri Maina, MD
[ ] Thomas Scott, MD
[ ] Michael Polcari, MD

AAAC LOCATION REQUEST:
[ ] Homewood
[ ] Hoover
[ ] Chelsea
[ ] Alabaster
[ ] Cullman
[ ] Trussville
[ ] Bessemer MEDICAL WEST
[ ] Oxford
[ ] Food Allergy Treatment Center
[ ] Clinical Research Center of Alabama

REFERRING PROVIDER: _____

SENT BY (Person sending this form): _____

REFERRING PHONE NUMBER: _____

REFERRING FAX NUMBER: _____

Please include patient labs and past clinic notes as appropriate with this referral.

We accept all major insurance policies. If the patient's insurance requires a referral from their primary care provider to see a specialist please include the referral with this form (i.e. Medicaid, Tricare Prime, Healthsprings, some BC/BS)

*Development and Marketing Questions, 205-422-3553*
*Refererral Coordinator, 205-209-4107*