Alabama Allergy & Asthma Center

FAX REFERRAL FORM

PLEASE FAX THIS FORM TO
205.449.6101

PATIENT DEMOGRAPHICS

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
- ☐ Oxford
- ☐ Bessemer (MEDICAL WEST)
- ☐ Fort Payne
- ☐ Food Allergy Treatment Center
- ☐ Clinical Research Center of Alabama

REFERRAL INFORMATION

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, some BC/BS).