Allergy & Asthma Centers
Helping patients with allergic disorders to enjoy life

Physician Referral Form

Appointment Type: Consult--- Consult and Treat--- Consult and Ongoing Care--- Other---

Reason for Referral_______________________________________

Any Testing Performed: Type________________________________

Patient record in Athena__Y/N_

<table>
<tr><td colspan="3">Patient Name:</td></tr>
<tr><td>Date of Birth:</td><td></td><td>Sex: M F</td></tr>
<tr><td colspan="3">Home Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip Code:</td></tr>
<tr><td>Home Phone:</td><td>Cell Phone:</td><td>Work Phone:</td></tr>
<tr><td colspan="3">Email Address:</td></tr>
</table>

<table>
<tr><td>Insurance Information:</td><td>Copy of Insurance Card Attached__Y/N__</td></tr>
<tr><td>Policy Holder:</td><td>Date of Birth:</td></tr>
<tr><td colspan="2">Insurance Provider:</td></tr>
<tr><td>ID Number:</td><td>Group Number:</td></tr>
<tr><td colspan="2">Does the patient need an interpreter? Yes No Language Needed</td></tr>
<tr><td>Referring Physician:</td><td>Contact Person:</td></tr>
<tr><td>Office Phone:</td><td>Office Fax:</td></tr>
<tr><td>Preferred Method of Communication: Office__</td><td>Cell Phone__Athena Message__(if applicable)</td></tr>
<tr><td colspan="2">Office Address: 12750 Horseferry Rd STE 100 Carmel, IN 46032</td></tr>
<tr><td colspan="2">Primary Physician: (if different than referring)</td></tr>
<tr><td colspan="2">Carmel Allergy will fax back:
Appointment Date and Time:</td></tr>
<tr><td colspan="2">Physician:</td></tr>
<tr><td colspan="2">NPI:</td></tr>
<tr><td colspan="2">Location: 12750 Horseferry Rd STE 100 Carmel, IN 46032</td></tr>
<tr><td colspan="2">Please send the following clinical information:
---Labs (6mo-1yr.) --- Imaging --- Office Notes (1yr.) --- Other_________________________</td></tr>
</table>

If you do not receive confirmation of an appointment within 48 Hours, please contact us

Carmel Allergy
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Fax: 317-564-4438
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