David T. Plaxico, MD
Allergy& Asthma Clinic of Macon
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Pediatric & Adult Allergy
Fellow-American Academy of
Allergy Asthma & Immunology

Clinical Immunology
Fellow-American Academy
Pediatrics

REFERRAL FOR ALLERGY/ASTHMA EVALUATION & TREATMENT

Please complete the information below, attach requested documents and fax back. We will contact the patient and set an appointment with them based on their schedule.

Would you like to be contacted by fax/phone when appt. had been made? ______Y ______N

Referring DR. ___________________________________

Contact Person _________________________________

Ref. Dr. Phone # ________________________________

Ref. Dr. Fax # __________________________________

Ref. Dr. Upin # _________________________________

Ref. Dr. NPI # __________________________________

PATIENT _______________________________________

DOB: _________ (If a child) Contact Name ___________

Address____

____

Home # __________________ Cell# ________________

<u>We DO NOT accept Workers Comp.</u>

PRIMARY INSURANCE

Ins Name: ______________________________________

Policy # ____

Group # ____

Policy Holder __________________ DOB ____________

Ins Phone # _____________________________________

SECONDARY INSURANCE

Ins Name: ______________________________________

Policy # ____

Group # _______________________________________

Policy Holder __________________ DOB ____________

Ins Phone # _____________________________________

Please attach all recent **LABS, XRAYS**, office notes, ER discharge summary and/or any Allergy Skin / Rast testing (that has been done) for your patient. This is needed so we can make the correct type of appointment for the patient and not repeat any procedures.

ALL PATIENTS UNDER 18 YRS OLD – WE MUST HAVE A COPY OF THEIR IMMUNIZATION SHOT RECORD.

Please give a brief explanation as to why patient needs an Allergy/Asthma evaluation:____________________________

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Thank you for your referral,

David T. Plaxico, MD