ALLERGY, ASTHMA & IMMUNOLOGY CONSULTANTS

REFERRAL FORM

PERSONAL INFORMATION

Full Name :

AUTHORIZED CONTACT PERSON IF DIFFERANT THAN PATIENT :

Date Of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** : _____

Insurance Company : _____ **Insurance Co phone Number** _____

Policy ID No : _____ **Group No** : _____

Authorization Information* (e.g. #, # visits allowed, expiration date): _____
If Authorization is required, referring physician/clinic must complete prior to referral.

*****If patient is a child, it is REQUIRED to include Guarantor/Guardian Information*****

Subscriber/Guarantor Name : _____ **Subscriber/Guarantor DOB** _____

Subscriber/Guarantor Address: _____ **Relation to patient** _____

REQUESTING PROVIDER INFORMATION

Name : _____ **Phone Number** : _____

Mailing Address : _____

Contact person : _____ **Fax Number** : _____

REASONS FOR REFERRAL

Reason for appointment : _____

Diagnosis/Problem : _____

Current medications : _____

More Information :

1173 NW 64TH TERRACE
GAINESVILLE, FL 32605

+(352) 331-2485 (Office)

admin@aaicinfo.co

All applicable clinical notes, recent lab work, radiological interpretations, copies of front and back of insurance cards, and any other pertinent information should accompany this request