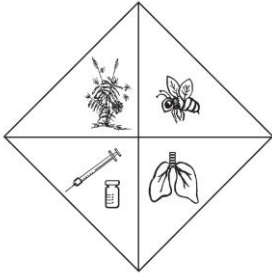

FAX REFERRAL FORM
Allergy Institute, P.C.
1701 22nd street, Suite 207
West Des Moines, IA 50266
Phone: (515) 223-8622
Fax: (515) 223-5324

Dr. Vuong Nayima, D.O.

Laura Jetter, ARNP

DATE:____________________

PATIENT NAME:____________________

DATE OF BIRTH:____________________

ADDRESS:____________________

PARENT/LEGAL GUARDIAN NAME:____________________

CONTACT PHONE NUMBER(S):____________________

REASON FOR REFERRAL/CONSULT:____________________

____

PATIENT INSURANCE:____________________

Patients with UHC Compass, Humana HMO, TRICARE Prime Remote Require Prior Authorization

*NPI # OF REFERRING PROVIDER (**IF ONE OF THE ABOVE INSURANCE**):*____________________

*# OF AUTHORIZED VISITS:*____________________ *AUTHORIZATION TIME FRAME:*____________________

REFERRING PROVIDER:____________________ SENT BY:____________________

REFERRING PHONE#:____________________ REFERRING FAX #:____________________

LOCATION (CIRCLE):

MAIN OFFICE	SKIFF SPECIALTY CLINIC	DALLAS COUNTY HOSP	CLARKE COUNTY HOSP	MERCY NORTH BLDG
1701 22ND ST, STE 207	*300 N. 4TH AVE E*	*610 10TH ST*	*800 S. Fillmore*	*800 East 1st St, Suite E230*
***WEST DES MOINES**, IA 50266*	***NEWTON**, IA 50208*	***PERRY**, IA 50220*	***OSCEOLA**, IA 50213*	***ANKENY**, IA 50021*

Once we schedule your patient, we will fax their appointment date back to you. We will fax our clinic notes after the patient's visit. **Please include patient labs and past clinic notes as appropriate.** Thank you for partnering with us on your patient's care!

For Allergy Institute Office Use:

Appointment date:____________________ Time:____________________
Physician:____________________ Location:____________________
Staff Initials:____________________ Date Faxed:____________________