FAX REFERRAL FORM

Allergy Institute, P.C.

2001 Westown Pkwy, Suite 107
West Des Moines, IA 50265
Phone: (515) 223-8622
Fax: (515) 223-5324

DATE:_____

PATIENT NAME:_____DATE OF BIRTH:_____

ADDRESS:_____

PARENT/LEGAL GUARDIAN NAME:_____

CONTACT NUMBER(S):_____

REASON FOR REFERRAL/CONSULT:_____

PATIENT INSURANCE:_____ID#_____

REFERRING PROVIDER INFO:

PROVIDER NAME: _____ NPI:_____

PHONE NUMBER:_____ FAX NUMBER: _____

REFERRING FORM COMPLETED BY:_____

Patients with Tricare Prime and Prime Remote:

- Please attached Tricare authorization form:
- Please complete the following information:

Does this patient need an interpreter? Y /N

Language requested _____

Sponsors name: _____ Sponsors DOB:_____ Sponsors SSN/DOD:_____

Location (Circle):

Main office	**Skiff Specialty Clinic**	**Dallas Co. Hospital**	**Clarke County Hosp**	**Ankeny Office**
2001 Westown Pkwy, STE 107	300 N. 4th Ave E	610 10th Street	800 S. Fillmore	3720 N Ankeny Blvd, STE 100
West Des Moines, IA 50265	**Newton**, IA 50208	**Perry**, IA 50220	**Osceola**, IA 50213	**Ankeny**, IA 50023

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:_____Provider:_____
Location:_____Staff Initials:_____ Date Faxed:_____

Fadi Alkhatib, D.O. **Laura Jetter, ARNP** **Alexandra Jansen, DNP**