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

DATE:_____

PATIENT NAME:_____ DATE OF BIRTH: _____/_____/_____

ADDRESS:_____

PARENT/LEGAL GUARDIAN NAME:_____ CONTACT No: _____

REASON FOR REFERRAL/CONSULT:_____

PATIENT INSURANCE:_____ID#_____

PROVIDER NAME: _____ NPI:_____

REFERRING FORM COMPLETED BY:_____

PHONE No: _____ FAX No: _____

Patients with Tricare Prime and Prime Remote:

- Please attached Tricare authorization form
- Please complete the following information:
- Sponsors Name: _____ Sponsors DOB:_____Sponsors /DOD:_____

Does this patient need an interpreter? Y /N

Language requested:_____

Please Circle Location:

Main Office
1701 22nd St, Suite 207
West Des Moines, IA 50266

Skiff Specialty Clinic
300 N 4th Ave E
Newton, IA 50208

Dallas Co. Hospital
610 10th Street
Perry, IA 50220

Clarke Co. Hospital
800 S. Fillmore
Osceola, IA 50213

Mercy North BLDG
800 East 1st St, Suite 2500
Ankeny, IA 50021

Walnut Street Health & Wellness
125 W Walnut St
Ogden, IA 50212

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**

REV 12/04/2020