AllerVie HEALTH

Alabama Fax Referral Form

Patient Demographics

Date: _____

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian: _____

Contact Phone Number: _____ Alternate Phone Number: _____

Patient Insurance: _____

Reason for Referral or Consult: _____

***INSTRUCTIONS:** Please indicate either a specific provider or a location preference. Please note that not all AllerVie providers see patients at all locations.*

AllerVie Health Provider Request

- ☐ John Anderson, MD
- ☐ Sunena Argo, MD
- ☐ Mark Kalenian, MD
- ☐ Shashi Kumar, MD
- ☐ Njeri Maina, MD
- ☐ William Massey, MD
- ☐ J. Allen Meadows, MD
- ☐ Michael Polcari, MD
- ☐ Thomas Scott, MD
- ☐ Maxcie Sikora, MD
- ☐ Weily Soong, MD

AllerVie Health Location Request

☐ Alabaster	Fax: 205.449.6101	☐ Hoover	Fax: 205.449.6101
☐ Chelsea	Fax: 205.449.6101	☐ Huntsville	Fax: 256.536.1504
☐ Cullman	Fax: 205.449.6101	☐ Jasper	Fax: 205.449.6101
☐ Dothan	Fax: 334.671.1905	☐ Montgomery	Fax: 334.272.6019
☐ Enterprise	Fax: 334.671.1905	☐ Oxford	Fax: 205.449.6101
☐ Food Allergy Treatment Program	Fax: 205.449.6101	☐ Trussville	Fax: 205.449.6101
☐ Fort Payne	Fax: 205.449.6101	☐ Clinical Research Center of Alabama	Fax: 205.449.7282
☐ Homewood	Fax: 205.449.6101		

Referral Information

Referring Provider: _____ Referring Provider NPI: _____

Sent by (Person sending this form): _____

Referring Phone Number: _____ Referring Fax Number: _____

Please include patient labs and past clinic notes as appropriate with this referral.

We accept most major insurance policies. If the patient's insurance requires a referral from their primary care provider to see a specialist, please include the referral with this form.