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**Patient Demographics**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Patient Insurance: \_\_\_\_\_

Reason for Referral or Consult: \_\_\_\_\_

**AllerVie Health Network Locations in Texas**

Midland  
P 432.682.5385 | F 432.682.1265

Lubbock - 19th Street  
P 806.795.4391 | F 806.796.1354

Lubbock - 22nd Street  
P 806.799.4192 | F 806.799.6299

Lubbock - Quaker Ave.  
P 806.799.4192 | F 806.799.6299

**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.*