AllerVie HEALTH

Texas Fax Referral Form

allervie.com

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 806.329.3415 | **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.

Looking for a clinical trial? If you would like to refer a patient to AllerVie Clinical Research, please visit us at **allervieresearch.com**

AllerVie CLINICAL RESEARCH