

# Carolina Asthma and Allergy Center **Appointment Referral Fax Form**

Phone: (704) 998-0965 for Scheduling / Referral Fax: (704) 644-1827

*Please complete ALL information listed below to help us process this referral and expedite treatment to your patient.*

**Name of Referring Practice:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**Patient Information**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Parents/Guardian's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Interpreter Needed**    Type:  Spanish    Hearing Impaired    Other: \_\_\_\_\_

**Insurance Information**

**Primary Insurance:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Authorization/NPI#: \_\_\_\_\_ # of Visits: \_\_\_\_\_ Effective Dates: \_\_\_\_\_ to \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Authorization/NPI#: \_\_\_\_\_ # of Visits: \_\_\_\_\_ Effective Dates: \_\_\_\_\_ to \_\_\_\_\_

**Symptoms:** \_\_\_\_\_

**Offices and Physicians:**

CAAC at East 7 <sup>th</sup> Street	CAAC at Ballantyne	CAAC of Concord	CAAC of Gastonia
<input type="checkbox"/> Caicedo <input type="checkbox"/> Lapuente <input type="checkbox"/> Collins <input type="checkbox"/> Norris <input type="checkbox"/> Errington <input type="checkbox"/> Patel <input type="checkbox"/> Herring <input type="checkbox"/> Roberts <input type="checkbox"/> Hungness <input type="checkbox"/> Seiler <input type="checkbox"/> Klimas <input type="checkbox"/> Silton	<input type="checkbox"/> First Available <input type="checkbox"/> Collins <input type="checkbox"/> Silton <input type="checkbox"/> Errington <input type="checkbox"/> Lapuente <input type="checkbox"/> Norris (starting 11/1/12) <input type="checkbox"/> Patel (starting 11/1/12)	<input type="checkbox"/> First Available <input type="checkbox"/> Collins <input type="checkbox"/> Errington <input type="checkbox"/> Herring <input type="checkbox"/> Klimas <input type="checkbox"/> Patel	<input type="checkbox"/> First Available <input type="checkbox"/> Lapuente <input type="checkbox"/> Roberts <input type="checkbox"/> Seiler <input type="checkbox"/> Silton
CAAC of Lake Norman	CAAC of Monroe	CAAC of Rock Hill	CAAC at University
<input type="checkbox"/> First Available <input type="checkbox"/> Hungness <input type="checkbox"/> Norris <input type="checkbox"/> Patel <input type="checkbox"/> Roberts	<input type="checkbox"/> First Available <input type="checkbox"/> Caicedo <input type="checkbox"/> Collins <input type="checkbox"/> Hungness <input type="checkbox"/> Lapuente	<input type="checkbox"/> First Available <input type="checkbox"/> Errington <input type="checkbox"/> Hungness <input type="checkbox"/> Klimas <input type="checkbox"/> Patel	<input type="checkbox"/> First Available <input type="checkbox"/> Klimas <input type="checkbox"/> Norris <input type="checkbox"/> Seiler <input type="checkbox"/> Roberts

**IF YOU HAVE NOT RECEIVED A RESPONSE TO THIS FAX IN 3 BUSINESS DAYS PLEASE CONTACT OUR SCHEDULING SUPERVISOR IMMEDIATELY AT 704-998-0903.**

[ ] We attempted to reach your patient on \_\_\_\_\_ and \_\_\_\_\_, but were unable to contact them  
 A voicemail was left     We were unable to leave a message

[ ] Your patient's appointment is scheduled for \_\_\_\_\_ at \_\_\_\_\_ with Dr. \_\_\_\_\_.