Carolina Asthma & Allergy Center

Appointment Referral Fax Form-Hickory Office
Phone: (828)327-0600 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: _____ Gender: _____

Address: _____ City: _____ State_____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Parents/Guardian's Name: _____ Parents' DOB _____ Relationship:_____

❑ **Interpreter Needed** **Type: ❑ Spanish ❑ Hearing Impaired ❑ Other:** _____

Insurance Information

(Please include front and back copies of the patient's card)

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: _____

Hickory Office Physician: **Sarbjeet K. Sran, MD**

HIS Direct Email Address: sarbjeet.sran.p1@direct.caac.nextgenshare.com

If you have not received a response to this fax in 5 business days please contact us at 828-327-0600
We will send you an appointment confirmation sheet back after we have tried to contact your patient.
If you prefer, you may send referrals directly from your Electronic Health Record System as we are participating in the Health Information Systems Program.