

**Request for
Consultation**

**asthma : allergy center ltd
Asif Khan M.D.
36001 Euclid Ave. Suite C19
Willoughby, OH 44094
(440) 306-2335, fax (440) 510-0518
www.passionandprofession.com/allergy**

REFERRING PHYSICIAN INFORMATION

Date: _____

Name: _____ UPIN/NPI: _____
Clinic Name _____
and address: _____ City/State/Zip: _____
Telephone: _____ Fax: _____ Specialty: _____

PATIENT INFORMATION

Gender: M F (please circle) SS#: _____ Email: _____
Name: First _____ Middle: _____ Last: _____
Address: _____ City: _____
State/Zip: _____ County: _____ DOB: _____
Parent's name (if Minor): _____ Spouse's name: _____
Insurance: _____ Policy #: _____
Home Phone #: _____ Work Phone #: _____
Contact instructions (preferred number/best time to reach/OK to leave message)

REQUESTED APPOINTMENT

Reason for Referral, Symptoms, and Prelim Diagnosis:

Brief Past Medical History:

Pertinent Meds:

Notify Primary Care Physician after visit?: Y N (please circle one)

If Patient requires allergy immunotherapy, the AAC will be happy to administer this unless the PCP prefers to administer the injections in the their office. Please indicate preference _____