PATIENT REFERRAL FORM

Date of Referral: _____

Referring to:

❒ **Fremont Clinic**
3448 Mowry Avenue
Fremont, CA 94538
Ph: (510) 254-5403
Fax: (844) 898-6128

❒ **Oakland Clinic**
80 Grand Avenue, 5th Floor
Oakland, CA 94612
Ph: (510) 422-1857
Fax: (844) 898-6128

❒ **Sunnyvale Clinic**
520 Lawrence Exp, Suite 303
Sunnyvale, CA 94085
Ph: (408) 837-9699
Fax: (844) 898-6128

❒ **Redwood City Clinic**
80 Arch Street
Redwood City, CA 94062
Ph: (650) 229-5778
Fax: (650) 368-6872

❒ **San Mateo Clinic**
101 S. San Mateo Drive, #311
San Mateo, CA 94401
Ph: (650) 832-9232
Fax: (650) 696-8229

❒ **San Leandro Clinic**
13847 E. 14th Street, Suite 112
San Leandro, CA 94578
Ph: (510) 757-9077
Fax: (510) 352-8644

Patient name: _____

Date of Birth: _____ **Phone:** _____

Address: _____ **Insurance:** _____

_____ _____

Reason for Referral:

❒ Acute Rhinitis
❒ Allergic Asthma
❒ Allergic Rhinitis
❒ Anaphylaxis
❒ Angioedema
❒ Vasomotor Rhinitis
❒ Atopic Dermatitis
❒ Bee Allergy
❒ Chronic Sinusitis
❒ Cough-Variant Asthma
❒ Environmental Allergies
❒ Other
❒ Exercise-induced Asthma
❒ Medication Allergy
❒ Food Allergy
❒ Non-Allergic Rhinitis
❒ Urticaria

Please Send Chart Notes

Referring Doctor: _____

Phone: _____ **Fax:** _____

Notes: _____

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