REGIONAL ALLERGY, ASTHMA & IMMUNOLOGY CENTER

REFERRAL FORM

Shailee Madhok, M.D., FACAAI

Phone: 423-246-6445 Fax: 423-246-8240

www.regionalallergycenter.com

8 Sheridan Square Ste. 201 Kingsport TN 37660

2312 Knob Creek Rd, Ste. 208, Johnson City, TN 37604

16000 Johnston Memorial Drive, Suite 212, Abingdon, VA 24211

Date: _____

Patient: _____ DOB: _____ Gender: _____

Address: _____

City/State/Zip: _____

Social Security #: _____ Phone: _____ Cell Phone: _____

Insurance: _____ Policy #:_____Group#:_____

Secondary: _____ Policy#:_____Group#:_____

Parent/Guardian Name: _____

Policy Holder Name: _____ SSN#:_____ DOB: _____

Reason for Referral: _____

Location Preferred: _____Kingsport _____Johnson City _____ Abingdon

Referring Physician: _____ Phone#:_____

Referral # (if required by insurance) _____

Any additional Comments (if patient is on antihistamines, etc.):

Please send recent progress notes and labs with referral.

Please send updated Copy of insurance card that is legible.