

**Allergy, Asthma, &
Immunology Clinic**

FAX: 504.903.1605

Patient Label/Stamp

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Attending Provider: _____ ID Number: _____

If Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ____/____/____

Date of Birth: ____/____/____ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email Address: _____

Please Indicate Reason for Referral:

- 995.3 Allergic Reaction, unknown agent/allergen
- 477.9 Allergic Rhinoconjunctivitis
- 995.0 Anaphylaxis and Anaphylactoid reactions
- 691.8 Dermatitis, atopic
- 692.9 Dermatitis, contact
- 99.12 Drug Desensitization
- 99.12 Egg Allergic patient needs desensitization for immunizations
- 995.60 Food Allergies
- 989.5 Hymenoptera (Bee Sting Allergy)
- 279.9 Immunodeficiency--NOT HIV related
- 708.9 Urticaria
- Other ICD: _____ Diagnosis: _____

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ **ID Number:** _____

Contact Number: _____ **Referring Service/Clinic:** _____

Fax Number: _____ **Email:** _____

OFFICE USE ONLY: Appointment Date: ____/____/____ Time: __:__ am/pm.

IF not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number _____

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