allergy associates of La Crosse

Allergy Associates of La Crosse
Referring Provider Fax Cover Sheet

Please Note: Please send only relevant allergy information and records.

Fax Form Referral documents to Allergy Associates of La Crosse: 608-782-6172

Date: _____ Number of Pages (including cover): _____

From: Provider name:
Clinic Name:
Provider Phone:
Preferred Provider optional

Body:

Patient Name:
Patient Phone:
Patient DOB:

if applicable -
Parent or Guardian Name:
Relationship to Patient:

Referral Reason:

◯ Provider would like a return phone call to discuss

◯ Provider requires no further communication from Allergy Associates of La Crosse

☐ I would like chart notes sent back after first appt

*Please send only relevant allergy information and records.