



**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

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.

CONFIDENTIALITY NOTICE: The Personal Health Information contained in this FAX is confidential and intended for the exclusive use of Allergy Associates of La Crosse. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is a violation of Federal Laws (HIPAA). If you have received this message in error, thank you for notifying the sender.