# Request for Consultation

# asthma : allergy center

# Asif Khan M.D.

**Referring Physician Information** Date: _____

Name: _____ UPIN/NPI: _____

Clinic Name
And Address: _____ City/State/Zip: _____

Telephone: _____ Fax: _____ Specialty: _____

**Patient Information**

Gender: M F SS#: _____ Email: _____

Name: First: _____ Middle Initial: ___ Last: _____
(parent's name if minor)

Address: _____ City/State/Zip: _____

Insurance: _____ Policy #: _____

Home Phone: _____ Work Phone: _____

☐ check if OK to leave message

**Requested Appointment**

Reason for Referral, Symptoms, Prelim Diag: _____

Notify PCP after visit? (circle) Y N

If the patient requires immunotherapy the AAC will be happy to administer it at our office unless the PCP prefers to administer it in their office. Please indicate: (circle) AAC PCP

**Please Check Office Required:**


5 36001 Euclid Ave., C19
Willoughby, Ohio 44094
(O) 440.306.2335
(F) 440.510.0518

5 3040 Belmont Ave.
Liberty, Ohio 44505-1836
(O) 330.759.3415
(F) 330.759.9215

5 16 South Main St.
Poland, Ohio 44514
(O) 330.757.2459
(F) 330.759.9215


Please visit our website **www . MyAllergyCenter . com** to save time for your patients!

Please attach copy of patient's insurance card/information if available