REFERRAL FORM

San Francisco
Allergy | Asthma | Immunology

Thank you for choosing to refer your patient to San Francisco Asthma, Allergy, and Immunology. To start the referral process, please complete this form and fax it directly to the clinic.

- **Send brief, pertinent medical records, including test results and imaging that support the consultation.**
- **Send a copy of the patient's demographics, insurance card (both sides), and HMO authorization as appropriate.**
- **Brain fog, chronic fatigue, chemical sensitivity, dysautonomia, Ehlers-Danlos, POTS, dizziness, neuropathic pain, numbness/tingling, vertigo, and hypertension are not treated by allergists. Testing is NOT AVAILABLE for chemical sensitivity or mold toxicity. Referrals for these symptoms or diagnoses will be returned to the ordering provider.**
- **Referrals missing information may experience processing delays. For help referring a patient, call (415) 362-2614.**

Date _____ **From** _____

No. of pages _____ **Ph #** _____

To Dr. (Please circle): Gupta Davidson Arja Any **Fax #** _____

Fax (415) 362-2615

PATIENT INFORMATION

Name of patient

DOB

Home phone **Cell phone**

Address

City **State** **Zip**

Insurance

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-10

Reason for consultation

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD and Specialty

Phone **Fax**

Primary care provider **Phone**