GRAVES GILBERT CLINIC

Please call for an appointment, then fax this referral and records to our office **or** fax the referral and we will make the appointment for your patient and fax info back to your office.

Allergy Department Referral

In order to better service the needs of our patients, please fill out and return to our office. Additionally we will need copies of **insurance cards and all pertinent medical records for the referral including office notes, labs, and any x-rays (chest and/or sinus).**

GGC Allergy Phone is 270-780-0560 Fax is 270-780-0467

M D Preference: First Available or P. Mercer, M. D. T. Sternberg M. D. J. Parkerson, D.O. K. Gardner, M.D.
Should we schedule your patient in the Bowling Green office (2724 Nashville Rd) or the Glasgow office (1330 N. Race St)
Circle which provider/location you would like the patient to see. If you have no preference, we will schedule the patient with first available doctor.

Patient Information:

Patient Name: _____ Date of Birth: _____

Patient Address: _____City/State/Zip_____

SS#: _____ Home phone: _____ Cell Phone: _____

Patient guardian Name (if applicable): _____ Phone: _____

Patient Insurance (Please send copy of insurance cards): _____ ID# _____

Patient Primary language: English or _____ Interpreter needed: Yes or No

Referring Provider information

Referring Provider Name: _____ Phone : _____
Contact Person: _____ Fax : _____

PCP information: **If you are not the patient's primary care physician, please complete this section.**

Primary Care Physician: _____ Phone: _____

Reason for referral (circle all that apply):

nasal or sinus symptoms asthma or chest symptoms Urticaria/hives
immune system workup food issues anaphylaxis Stinging insect allergy angioedema

other: _____

Please attach all pertinent office notes, labs, and/or x-rays (any chest or sinus) done on this patient.

Appointment Details:

An appointment is scheduled with Dr. _____ in the _____ office on _____ at _____ am/pm. The patient should arrive by _____ am/pm to complete their registration. We will mail the patient a new patient packet 2 weeks prior to their appointment. If they do not receive the information, please have them contact our office.

Patient Notified of the appointment on _____ by _____

As always, thank you for your referral. We strive to provide the best Allergy care to your patients.