



5002 Cowhorn Creek Drive  
 Texarkana, Tx. 75503  
 Phone: (903) 614-3010  
 Fax: (903) 614-3518

**ALLERGY**

**CONSULT** (Request for advice / opinion) or  **REFERRAL** (Request for management of care)  
 (Please only select one request)

**REQUESTING PROVIDER INFORMATION**

Requesting Provider Name		Requesting Provider Address (street, city, state, zip)	
Requesting Provider Telephone	Requesting Provider Fax Number	NPI #	
(    )       -	(    )       -		

**APPOINTMENT REQUEST**

**DIAGNOSIS**

<input type="checkbox"/> <b>Sharon H. Richter, MD</b> <input type="checkbox"/> <b>Frank F. Lachowsky, MD</b>	
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**PATIENT and INSURANCE INFORMATION**

Patient Name (First, Middle Initial, Last)	Gender
	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	City, State, Zip

Date of Birth (mm/dd/yyyy)	Social Security #
/  /	-  -

Home Telephone	Mobile Telephone	Work Telephone
(    )       -	(    )       -	(    )       -       xtn

Does patient need an interpreter?	If yes, what language?
<input type="checkbox"/> Y <input type="checkbox"/> N	

Does the patient have medical insurance?	Name of Insurance Company and Plan Number and Group Number
<input type="checkbox"/> Y <input type="checkbox"/> N	

**DOCUMENTATION**

*Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3518.  
 Thank you in advance for the request and your cooperation.*