**** *Consult / Referral Forms are now available on-line at www.cccahealth.com* ****

Collom & Carney Clinic ASSOCIATION

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Phone: (903) 614-3010
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# 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 |
|---|---|
| ☐ **Frank F. Lachowsky, MD** | |

## PATIENT and INSURANCE INFORMATION

| Patient Name (First, Middle Initial, Last) | Gender |
|---|---|
| | ☐ Male ☐ 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? |
|---|---|
| ☐ Y ☐ N | |

| Does the patient have medical insurance? | Name of Insurance Company and Plan Number and Group Number |
|---|---|
| ☐ Y ☐ 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.*

*Collom & Carney Clinic OFFICE USE ONLYPlease scan form to Chart Note for Clinic Physician*

| Patient MR # | Patient ID # |
|---|---|