Scheduling Line: 909-651-1901
Fax: 909-651-4257

Referral Form
Pediatric Allergy/Immunology/Pulmonary

Patient Information	
Does this patient live with someone other than the legal guardian? □ No □ Yes, relationship _________________	
Patient Name:	Date of Birth:
Parent/Guardian:	Parent/Guardian Phone:
Insurance:	

1. Please select the type of referral: □ STAT □ Urgent □ Routine
If Stat or Urgent, please call our doctor-to-doctor line (909) 558-0099

2. Is this referral for a second opinion? □ **No** □ **Yes**

3. What is the key question you want us to answer? ____
____

Please select diagnosis:

□ **Allergic Rhinitis**	□ **General Pulmonary**
□ **Allergy**	□ **Recurrent Sinus Infections**
□ **Anaphylaxis**	■ **Sleep Apnea (refer to Pediatric Neurology)**
□ **Asthma**	□ **Stinging Insect Sensitivity**
□ **Atopic Dermatitis**	□ **Urticaria/Hives**
□ **Drug Sensitivity / Allergic Reaction**	□ **Other**: Please explain
□ **Eosinophilic Esophagitis**	

To optimize appointment scheduling, please provide the following by FAX to 909-651-4257
- This completed form
- Medical records related to the chief complaint
- Lab and test reports from the last year, including respiratory cultures, pulmonary function, and allergy/immune testing
- Chest x-ray (film and report) for Asthma or General Pulmonary consult
- A copy of the patient's insurance card
- If authorization is required, was authorization submitted? □ **Yes** □ **No** □ **Not Applicable**

Referring Provider Information

Provider Name:	OR Provider Stamp
Address:	
City, State, Zip:	
Phone:	
Fax:	

***Please notify the patient to call our Scheduling Line to make an appointment: 909-651-1901.**