



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 #	
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APPOINTMENT REQUEST

DIAGNOSIS

<input type="checkbox"/> Sharon H. Richter, MD <input type="checkbox"/> Frank F. Lachowsky, MD	
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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 #
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Home Telephone	Mobile Telephone	Work Telephone
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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.*

Patient MR #	Patient ID #
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