AllerVie HEALTH

Georgia Fax Referral Form

allervie.com

Patient Demographics

Date: _____

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian: _____

Contact Phone Number: _____ Alternate Phone Number: _____

Patient Insurance: _____

Reason for Referral or Consult: _____

AllerVie Health Network Locations in Georgia

☐ **Columbus**
P 706.324.4012 | **F** 706.324.0396

☐ **Pooler**
P 912.513.2015 | **F** 912.303.9356

☐ **Savannah**
P 912.303.9355 | **F** 912.303.9356

View a complete list of providers and locations in the AllerVie Health network: allervie.com/locations

Referral Information

Referring Provider: _____ Referring Provider NPI: _____

Sent by (Person sending this form): _____

Referring Phone Number: _____ Referring Fax Number: _____

Please include patient labs and past clinic notes as appropriate with this referral.

We accept most major insurance policies. If the patient's insurance requires a referral from their primary care provider to see a specialist, please include the referral with this form.

Looking for a clinical trial? If you would like to refer a patient to AllerVie Clinical Research, please visit us at **allervieresearch.com**

AllerVie CLINICAL RESEARCH

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