IOWA ALLERGY
ASTHMA & IMMUNOLOGY P.C.

Fax Referral Form To: (844) 675-2792

Referring Offices Can Also Send Referrals Via Our Secure Website:

www.iowaALLERGYclinic.com

Vuong Nayima, D.O.
Kyla Reyes, DNP, ARNP, FNP-C

TODAY'S DATE: _____

REASON FOR REFERRAL/CONSULT: _____

_____

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____

PARENT/LEGAL GUARDIAN NAME: _____ PHONE #: _____

PATIENT INSURANCE: _____

Patients with Humana HMO, TRICARE Prime Remote, or UHC Compass need a prior authorization

NPI # OF REFERRING PROVIDER (**IF ONE OF THE ABOVE INSURANCE**): _____

OF AUTHORIZED VISITS: _____ AUTHORIZATION TIME FRAME: _____

PLEASE CIRCLE A LOCATION

Westown Medical Plaza

5901 Westown Parkway Suite 225

West Des Moines, Iowa 50266

Iowa Allergy Ankeny

800 East 1st Street Suite 2400

Ankeny, Iowa 50023

REFERRING PROVIDER: _____ REFERRING PHONE#: _____

SENT BY: _____ REFERRING FAX #: _____

Please include patient labs and past clinic notes as appropriate with your referral. Iowa Allergy will fax a patient's appointment back to your clinic once we schedule them. We will fax notes after patient's visit. We sincerely appreciate your referral and please do not hesitate to call with any questions.

Iowa Allergy Office Use Only:

Appointment date: _____ Time: _____

Staff Initials: _____ Date Faxed: _____