



**Dr. Vuong Nayima, D.O.**  
5901 Westown Pkwy  
Suite #225  
West Des Moines, IA 50266  
Phone: 515-410-9400

***Fax Referral Form To : 515-410-9401***

*Referring Offices Can Also Send Referrals Via Our Secure Website: [www.iowaallergyclinic.com](http://www.iowaallergyclinic.com)*

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: \_\_\_\_\_

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: \_\_\_\_\_