Mowery Clinic
Allergy and Clinical Immunology
Dr. Benjamin Rahoy

Allergy New Patient Consultation Request Form

Date: _____

First Name _____ Middle Initial _____ Last _____

Date of Birth _____ Home Phone _____ Cell Phone_____

Address _____City _____ State_____ Zip _____

Patient's Primary Care Physician _____Office # _____

Referring Physician_____Office #_____ Fax # _____

Health Insurance Company _____

Reason for Consultation Request (confirmed or suspected diagnosis):_____

_____

_____

☐ **Check box if URGENT and give REASON:**_____

Please fax completed form to 785-833-5709

For Office use:

☐ **Records attached** ☐ **Records in NextGen**

Sent to Triage Date: _____ **Initials**_____

Consultation Form and Medical Records Received (Date_____ **Initials** _____

For Faculty Triage use:

☐ **Approved; Reason:** _____

☐ **Declined; Reason:**_____

☐ **Urgent (range in weeks)**_____ ☐ **Send to Abby, RN**

☐ **Get additional records (specify records to request):** _____

Provider Reviewed: _____ **Date**: _____