C. Thomas Humphries, MD, MBA
William S. Ashe, Jr., MD
Hugh R. Black, II, MD

ASTHMA & ALLERGY SPECIALISTS, PA

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8045 Providence Rd.
Suite 300
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855 Sam Newell Rd.
Suite 206
Matthews, NC 28105

10310 Mallard Creek Rd.
Suite 101A
Charlotte, NC 28262

13557 Steelecroft Pkwy.
Suite 2200
Charlotte, NC 28278

3614 Providence Rd. S.
Suite 101
Waxhaw, NC 28173

Referral Form

Date:_____

Please fax form to: 1-855-380-2404 (toll free)
Email: npcoordinator@asthmanc.com

- ☐ **C.T. Humphries, MD, MBA**
- ☐ **William S. Ashe, Jr., MD**
- ☐ **Hugh R. Black, II , MD**
- ☐ **Vandana K. Patel, MD, FAAAAI**
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- ☐ **Arboretum Office**
- ☐ **Matthews Office**
- ☐ **University/Mallard Creek Office**
- ☐ **Steelecroft Office**
- ☐ **Waxhaw Office**

PATIENT INFORMATION

First/MI/Last Name:_____
DOB: _____ ☐M ☐ F
Contact Name & Phone: _____/_____
Address: _____
City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION (PLEASE PROVIDE A COPY OF THE INSURANCE CARD)

Insurance Company: _____
Subscriber ID#: _____ Group#: _____
Policy Holders Name: _____ DOB: _____
Referral Number: _____ Visits Authorized: _____

REFERRAL INFORMATION

Referring PCP: _____
Contact Name: _____
Fax Number: _____ Phone Number: _____

REASON FOR REFERRAL

- ☐ Asthma
- ☐ Cough
- ☐ Food Allergies
- ☐ Eosinophilc Esophagitis (EOE)
- ☐ Bronchitis
- ☐ Wheezing
- ☐ Eczema/Atopic Dermatitis
- ☐ Contact Dermatitis
- ☐ Shortness of Breath
- ☐ Exercise Induced Asthma
- ☐ Environmental Allergies
- ☐ Immune Evaluation
- ☐ Pneumonia
- ☐ Cystic Fibrosis
- ☐ Other:_____

APPOINTMENT SCHEDULED

Date: _____ Time: _____ Dr._____

Location:_____ Confirmed with patient: ☐ Yes ☐ No