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Allergy & Asthma Clinic of Macon  
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Pediatric & Adult Allergy  
Fellow-American Academy Of  
Allergy Asthma & Immunology

Clinical Immunology  
Fellow-American Academy Of  
Pediatrics

**REFERRAL FOR ALLERGY/ASTHMA EVALUATION**

Please complete the information below and fax to 478-743-4670

Would you like to be contacted by fax of the appt. date and time?  Y  N

Ref. Doctor \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

Contact Name \_\_\_\_\_

DOB \_\_\_\_\_ Patient SS# \_\_\_\_\_

Ref. Dr. Phone # \_\_\_\_\_

Address \_\_\_\_\_

Ref. Dr. Fax # \_\_\_\_\_

City \_\_\_\_\_ ZIP \_\_\_\_\_ - \_\_\_\_\_

Ref. Dr. UPIN # \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work# \_\_\_\_\_

Ref. Dr. NPI # \_\_\_\_\_

Contact Name \_\_\_\_\_

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Plan Name \_\_\_\_\_

Plan Name \_\_\_\_\_

ID # \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_

Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

Referral # from insurance company if required \_\_\_\_\_ . (attach copy)

Please fax any recent office notes, ER discharge summary, labs and sinus/chest x-rays, Allergy Skin Tests or Rast Tests for your patient.

Please give a brief explanation as to why this patient needs an allergy/asthma evaluation: \_\_\_\_\_

We accept all PPO plans. Currently we are in network with all plans in Aetna, Cigna, Tricare, UHC, Mohawk, Medicaid, Peachcare, and Peachstate with referral number if required by insurance. We will check all insurance plans before appointments are made to give the patient an estimate for treatment. **We do not accept → Amerigroup or Workers Comp.**

Thank you for your referral,



David T. Plaxico, MD