BAYOU ALLERGY TESTING

4140 Southwest Freeway #510
Houston, Texas 77027
Phone 713-621-2556 Fax 832-538-1619

Fax to: 832-538-1619
Please Attach Copy of Patient's Insurance Card and Patient's Photo ID Card

ALLERGY TESTING PRESCRIPTION FORM

Date:_____

PHYSICIAN INFORMATION HOUSTON FAMILY PHYSICIANS PA

Referring Physician **Khoa Nguyen, M.D.**
Address 8313 Southwest Frwy Ste 105
City/State/Zip Houston, Texas 77074

NPI#: 1427104678
Office #: 713-773-1102
Fax #: 832-369-7355

PATIENT INFORMATION

Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Telephone:_____ Work Telephone:_____ **Mobile:**_____
Email:_____ S.S.N.:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins Name:_____ **Telephone:**_____
ID:_____ **Group #:**_____

DIAGNOSIS

	472.0	Chronic rhinitis
	477.8	Allergic rhinitis
	473.9	Chronic sinusitis
	493.90	Asthma, unspecified
	691.8	Other atopic dermatitis and related conditions (food allergy)
	477.0	Allergic Rhinitis due to pollen
	477.8	Allergic Rhinitis due to other allergen
	692	Contact dermatitis and other eczema
	339.00	Headache
	995.0	Other anaphylactic shock

TYPE OF STUDY

X	95004	Percutaneous Allergy Skin Test
X	95024	Intradermal Allergy Skin Test

**Physicians Signature:_____

Physician signature is required on all referrals