

certified
ALLERGY & ASTHMA
consultants

THE MORE YOU KNOW, THE BETTER YOU'LL FEEL.

Referral Appointment Request Form

Date: _____

Patient Name: _____ DOB: _____

Parent's name if the patient is a child: _____

Patient's Phone Number: (____) _____

Patient's Insurance: Please check the Primary Insurance Only

☐ Aetna	☐ Anthem BC/BS	☐ MVP	☐ United Healthcare
☐ Highmark	☐ Medicaid	☐ NYS Empire Plan	☐ Fidelis
☐ CDPHP	☐ Medicare	☐ Champus/Tricare	☐ Other: _____

Insurance Policy or Identification Number: _____

Diagnosis/Symptoms: _____

Appointment Needed:

☐ ASAP ☐ 1st Available ☐ 1 Week ☐ 2 Weeks

PHONE: (518) 434-1446

FAX: (518) 434-0806

Location	☐ Albany, 8 Southwoods Blvd.	☐ Troy, 2231 Burdett Ave.
Preferred:	☐ Clifton Park, 7 Emma Lane	☐ Saratoga, 92 East Ave.
	☐ Niskayuna, 2125 River Rd.	

Schedule Appointment With: ☐ No Preference: or

Adult:	☐ Kemp Bundy, MD, MBA	☐ Michael Katlan, MD	☐ Luke Legakis, MD, PhD
Pediatrics:	☐ Saad Bakhaya, MD	☐ Kylie Jungles, MD	☐ Terese Copeland, MD
Nurse Practitioner:	☐ Nina Statile, FNP		

Referring Physician's Name: _____ **Phone Number:** (____) _____

Fax this form to our Referral Coordinator, Patty Dayter. Most patients will be contacted within 3 Business Days to schedule the appointment. If an insurance referral is required, please fax the referral to (518) 434-0806. Please attach all relevant office notes and labs. Contact us with any questions.

Conditions We Test & Treat

Allergies: Seasonal Allergic Rhinitis; Perennial Allergic Rhinitis; Chronic Rhinosinusitis (Allergic Sinus Disease); Bee Sting (Venom); Food Allergy; Contact Dermatitis; Penicillin Allergy

Asthma: Allergic Asthma; Non-allergic Asthma & Exercised Induced Asthma

Hives & Eczema: Urticaria/Angioedema; *Atopic Dermatitis

Immunology & Immunodeficiency: Recurrent Infections; Hypogammaglobulinemia (Low IgG); Common Variable Immunodeficiency (CVID)

**Adult Referrals require office notes and labs from PCP or Dermatologist for review prior to scheduling appointment.*

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