



Columbia Asthma & Allergy CLINIC

Fisher's Landing Clinic
1406 SE 164th Ave, Suite 250
Vancouver, WA 98683
Phone: (360) 940-0810
Fax: (360) 567-1967

Longview Clinic
1152 Douglas St.
Longview, WA 98632
Phone: (360) 940-0880
Fax: (360) 636-2237

Salmon Creek Clinic
2501 NE 134th, Suite 200
Vancouver, WA 98686
Phone: (360) 940-0820
Fax: (360) 737-3713

Bellevue Clinic
1700 116th Ave NE, 2nd Floor
Bellevue, WA 98004
Phone: (425) 209-0840
Fax: (425) 209-0778

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____ Insurance: _____

Reason for Referral:

- | | | |
|--|--|--|
| <input type="checkbox"/> Acute Rhinitis | <input type="checkbox"/> Atopic Dermatitis | <input type="checkbox"/> Exercise-Induced Asthma |
| <input type="checkbox"/> Allergic Asthma | <input type="checkbox"/> Bee Allergy | <input type="checkbox"/> Food Allergy |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Medication Allergy |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Contact Dermatitis | <input type="checkbox"/> Non-Allergic Rhinitis |
| <input type="checkbox"/> Angiodema | <input type="checkbox"/> Cough-Variant Asthma | <input type="checkbox"/> Urticaria |
| | <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Vasomotor Rhinitis |
| | | <input type="checkbox"/> Other |

PLEASE SEND CHART NOTES

Referring Doctor: _____

Date of Referral: _____ Phone: _____

Notes: _____