



# Allure Health Referral/Request Form

**A L L U R E**  
HEALTH  
TREATING YOU WELL

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## REFERRAL OR REQUEST REASON

- General Medical Care/Primary Care
- Medication Management
- Routine Physical or need for a General Physical
- Medicare Exams and Wellness Checks
- Chronic Medical Conditions - Health Maintenance & Prevention
- Infections: Fungal, Bacterial or Viral
- Anxiety, Depression or Mental Health
- Headaches & Migraines
- Weight Loss & Obesity
- Respiratory Conditions or Ailments
- Skin Disorders
- Other (not listed) \_\_\_\_\_

## WHAT WE NEED FROM YOU PRIOR TO SCHEDULING A VISIT:

- Recent Visit note from a Provider (each specialty if multiple providers)
- Recent Labs
- Recent Imaging
- Recent Pathology or Cultures
- Current Medication List
- Current Immunization Record
- Current Insurance Information
- Recent Surgical History
- List of Allergies

## YOUR INFORMATION:

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

City: \_\_\_\_\_

Email: \_\_\_\_\_@\_\_\_\_\_

State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

