NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE-DIVISION ALLERGY/IMMUNOLOGY

DATE_____________________

Physician's Signature________________________________

Physician's Name ____________________________________

CLIA ID Number
14D0688624

Physician's Address__________________________________

City_________________**State**________**ZIP**_______________

UPIN Number 201710

Phone No.(____)_____________________________________

Invoices will be mailed to the physician or lab requesting the test(s), or Medicare.
We cannot bill patients or insurance companies.

REQUIRED INFORMATION

Name (Last, First)____

Date of Birth (Month, Day, Year) ___________/___________/____________ **Last 4 Digits of Social Security Number** ________________

Sex _______ **Occupation** ____

Medicare Patient: Yes ______________ **No** ________________

ABPA Screen (total IgE, Af precipitins, specific E and G antibody to Af by ELISA).

First-time ABPA Screen___________________ **or Follow-up**______________________________________

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Source of Exposure__________________________**Provisional Diagnosis**____________________________

Onset of Asthma____

History of Infiltrates____

Skin Test: **Aspergillus Prick**_____________**ID**____

Eosinophilia____

Pulmonary Function Tests____

____

Serum IgE___________________________________**Sputum Culture**____________________________

CT of Lung____

Chest X-ray____

Current Medication____

Prednisone Dose____

<u>PLEASE SPECIFY WHERE RESULTS & INVOICES ARE TO BE MAILED:</u>

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<u>PLEASE RETURN THIS FORM TO:</u>

Paul A.Greenberger, M.D.
Northwestern University
Feinberg School of Medicine
DIVISION OF ALLERGY - IMMUNOLOGY
McGaw Pavilion, M-520L
240 East Huron St.
Chicago, IL 60611-2909
312-503-0208 - Phone
312-908-0210 – Fax