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ALLERGY, ASTHMA, & CLINICAL IMMUNOLOGY

Reason for referral (check all that apply):

- ☐ Asthma
- ☐ Allergic rhinitis
- ☐ Food allergy
- ☐ Stinging insect allergy
- ☐ Eczema
- ☐ Urticaria
- ☐ Anaphylaxis
- ☐ Penicillin allergy
- ☐ Other drug allergy
- ☐ Eosinophilic esophagitis
- ☐ Immunodeficiency
- ☐ Other (specify below)

Reason for referral/diagnosis: _____

Current Medications: _____

(List or Attach) _____

PATIENT INFORMATION

Last	First	☐ Mr. ☐ Mrs. ☐ Ms.
Address:	City	Postal Code
email	Home Phone	Mobile
Date of Birth	OHIP #	

PHYSICIAN INFORMATION

Referring Physician:	Phone Number:
Address:	Fax Number:
Billing Number:	CC to Family Doctor (if different):
Signature:	Family Doctor Phone:

Important: Patients must discontinue all antihistamines (including Gravol) at least 4 days prior to their scheduled appointment. Inhalers and nose sprays do not affect testing and can be continued as prescribed.

☐ Check here if you would like us to contact your patient directly. Please ensure patient's email and phone number are on this form. Our clinic prefers email correspondence.

PLEASE FAX ALL REFERRALS TO 1.866.881.7790