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ALLERGY, ASTHMA, & CLINICAL IMMUNOLOGY

Reason for referral (check all that apply):

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

*Penicillin, anesthetic, and insect venom allergy should be referred to the Adverse Reactions clinic at St. Joseph Hospital.

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 their antihistamine medications (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.

PLEASE FAX ALL REFERRALS TO 905.525.9548