Referral Form

Paediatric Allergy Clinic

Dr. Melanie Conway, M.D. FRCPC
Lakeridge Health, 3rd Floor, A wing
1 Hospital Court, Oshawa, ON
Tel: 905-576-8711, ext. 36390
Fax: 905-721-7774

Patient Information

Health Card Number: _____ Version Code: _____ DOB:_____

Last Name:_____ First Name: _____ Sex: M ☐ F ☐

Address:_____City:_____Postal Code:_____

Home Phone: _____ Cell Phone:_____

Referral Information

☐ Penicillin Allergy
☐ Food Allergy
☐ Urticaria/Angioedema
☐ Drug Allergy (non-Penicillin)
☐ Oral Food Challenge*
☐ Allergic Rhinitis/Conjunctivitis
☐ Insect Sting Allergy
☐ Primary Immunodeficiency
☐ Other: _____

Please provide reason for referral, relevant history, medications, lab test results and consultation reports.

*If referring for oral food challenge please also indicate the food allergen, results of skin testing, and ImmunoCap (if done). If possible, please provide a copy of your consult letter.

_____
_____
_____
_____
_____

Referring Professional

Name: _____ OHIP Billing Number: _____

Address:_____

City:_____ Postal Code:_____

Office Phone: _____ Fax:_____