Referral Form

Paediatric Allergy Clinic

Dr. Shama Sud
Lakeridge Health, 3rd Floor, C Wing
1 Hospital Crt, Oshawa, ON
Tel: 905-576-8711 Ext. 32376 Fax: (905) 721-4857

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.

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Referring Professional

Name: _____ OHIP Billing Number: _____

Address:_____

City:_____ Postal Code:_____

Office Phone: _____ Fax:_____