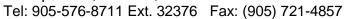
## **Referral Form**

## Paediatric Allergy Clinic

Dr. Shama Sud Lakeridge Health, 3<sup>rd</sup> Floor, C Wing 1 Hospital Crt, Oshawa, ON





Patient Information		
Health Card Number:	Version Code	e: DOB: Last
Name:	First Name:	Sex: M 🗌 F 🔲
Address:	City:	Postal Code:
Home Phone:	Cell Phone:	
Referral Information		
<ul><li>□ Penicillin Allergy</li><li>□ Food Allergy</li></ul>	□ Drug Allergy (non- Penicillin)	☐ Insect Sting Allergy ☐ Primary Immunodeficiency ☐
□ Urticaria/Angioedema	☐ Oral Food Challenge*	
	☐ Allergic Rhinitis/Conjunctivitis	Other:
Please provide reason for refreports.	ferral, relevant history, medications	, lab test results and consultation
G	llenge please also indicate the food possible, please provide a copy of you	G .
Poterring Protessional		
Referring Professional		
Name:	OHIP Billin	g Number:
Address:		
City:	Postal Code:	
Office Phone:	Fax	