McMaster Children's Hospital

Pediatric Allergy and Asthma Clinic Referral Request

Please fax completed form to **(905) 521-2654**

Contact booking desk (905) 521-2100 x73861 with any further inquiries

☐ Consult Only ☐ Urgent

☐ Consult and Follow-Up ☐ Non-Urgent

Patient's Last Name First Name

Address – Street City Postal Code

Telephone: ( ) Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) Age Gender ☐ M ☐ F

HIN Family Physician

***** **Important – Please read before referring** *****

- If the form is not completed in its entirety, it will be sent back for completion
- Our clinic does *not* evaluate patients with suspected Latex, Medication (EXCEPT for Penicillin), or Venom/Stinging Insect Allergies. With the *exception of Amoxicillin/Penicillin*, please re-direct your referral for the above concerns to the **Adverse Reactions Clinic at St. Josephs at Fax: (905) 523-5864**
- For Vaccine-related reactions/inquiries, please fax your referral to the above fax number but direct your referral to the **Pediatric Vaccine Clinic / Infectious Diseases**
- **Please instruct patient to avoid antihistamines for five days prior to their appointment**

If Parent / Guardian involved in client's care:

Name _____

Phone _____ Cell _____

E-mail *(required)* _____

Referral Date (yyyy/mm/dd) _____ OHIP Billing Number _____

Referring Physician (print) _____ Signature _____

Address _____ Telephone _____

E-mail (Optional) _____ Fax _____

REASON(S) FOR REFERRAL *(Please select all that apply)*

☐ Asthma ☐ Eczema ☐ Food Allergy ☐ FPIES

☐ Allergic Rhinitis ☐ Environmental / Seasonal Allergy ☐ Anaphylaxis ☐ Urticaria

☐ Cough ☐ Oral Food Challenge ☐ Other: _____

☐ EoE ☐ Allergic Reaction (1st visit is CONSULT ONLY) _____

Relevant details of Referral. If URGENT, please elaborate on reason for urgency:

_____

_____

_____

_____

Medications: _____

_____

Additional Information (please complete for appropriate triaging)

Other medical conditions: _____

_____

_____

_____

For Asthma: *In the past 12 months:*

☐ Oral Corticosteroid courses: _____

☐ Number of ED visits: _____

☐ Number of Hospitalizations: _____

Primary Language: _____ **Interpreter Required?** ☐ Yes ☐ No