Print Clear Form

Providence HEALTH CARE

ALLERGY AND CLINICAL IMMUNOLOGY REFERRAL

Place Patient Form Label Here

* 9 2 4 4 *

Allergy Immunology Referral

Date of Referral: _____
(dd/mmm/yyyy)

PATIENT INFORMATION:

Name: _____

PHN: _____

DOB: (dd/mmm/yyyy) _____

Phone: _____

Email: _____

Gender:
- ☐ Male
- ☐ Female
- ☐ Other: _____

Preferred language: _____
- ☐ Interpreter required

REFERRING PROVIDER:

Printed name: _____ MSP #: _____

Phone: _____ Fax: _____

PRIMARY CARE PROVIDER:

Printed name: _____

REASON(S) FOR REFERRAL:

_____

_____

_____

CURRENT MEDICATIONS: ☐ list attached with correspondence

_____ _____

_____ _____

_____ _____

INFORMATION ATTACHED:

- ☐ Relevant lab results over the duration of the illness
- ☐ Relevant consult reports for other physicians
- ☐ Copies of relevant imaging studies (include dates)
- ☐ Copies of all relevant discharge summaries

FAX completed referral and all relevant supporting documents to be triaged by SPH Allergy and Clinical Immunology. 604-602-8661