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Otolaryngology – Head and Neck Surgery

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Referral for Allergy Evaluation, Counselling and Immunotherapy Assessment

Please complete *all* information, you may append a patient label:

******An email address is important for communication******

Last Name	First	Middle	Provincial Health #	DOB (yyyy/mon/dd)

Gender	Street Address	City	Province

Postal Code	Home Phone #	Cell Phone #	Family Physician name

Referring Physician name	Referring physician phone #	Referring physician fax #

**Email Address:

- Patients will undergo allergy skin testing, counselling on the results, and consideration for immunotherapy and pharmacotherapy options
- Please note there is a fee to cover the cost of disposable equipment and allergen extracts
- **Please indicate any of the following conditions that have been previously diagnosed:**

☐ Chronic rhinitis
☐ Chronic sinusitis
☐ Nasal polyposis
☐ Conjunctivitis
☐ Asthma
☐ Eczema

- **Please indicate any of the treatments that are being used:**

☐ Topical nasal steroid spray
☐ Combination topical steroid/antihistamine spray
☐ Budesonide/saline rinses
☐ Oral antihistamine
☐ Montelukast
☐ Systemic oral steroid
☐ Nasal/sinus surgery is planned or has been performed
☐ Topical ipratropium spray

*****Please fax to 778-380-0833*****