



Referral for Allergy Evaluation, Counselling and Immunotherapy Assessment

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

*****A patient email address is required*****

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 #
**Patient's Email Address (required):					

- Patients will undergo allergy skin testing, counselling on the results, and consideration for immunotherapy and pharmacotherapy options
- Please note there is an \$80 charge to cover the cost of disposable equipment and allergen extracts
- **Please indicate any of the following conditions that have been previously diagnosed:**
 - Chronic rhinitis
 - Nasal polyposis
 - Asthma
 - Chronic sinusitis
 - Conjunctivitis
 - Eczema
- **Please indicate any of the treatments that are being used:**
 - Topical nasal steroid spray
 - Budesonide/saline rinses
 - Montelukast
 - Nasal/sinus surgery is planned or has been performed
 - Combination topical steroid/antihistamine spray
 - Oral antihistamine
 - Systemic oral steroid
 - Topical ipratropium spray

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