HAMILTON ALLERGY – CIRCUMCISION REFERRAL FORM

Hamilton Allergy
Dr. Jason Ohayon
Allergy & Immunology Clinic

Jason A. Ohayon MD FRCPC
Consulting Allergy and Clinical Immunology
1685 Main St. West Suite 201, Hamilton, ON L8S 1G5
905-777-0088, fax 905-777-0018

Referring Physician Information:

Name: _____

Address: _____

Tel #: _____

Fax #: _____

Email: _____

Physician billing #: _____

Will you notify the patient once an appointment has been scheduled?

☐ Yes, I will notify the patient about the appointment.

☐ No, Hamilton Allergy will notify the patient about the appointment.

Patient information:

Name: _____

Sex: ☐ **M** ☐ **F**

Date of Birth: _____

Address: _____

Home #: _____

Cell #: _____

Email: _____

Parent/Guardian Name (if applicable): _____

Health Card Number #: _____

Referral Information:

Age: _____ **Weeks:** _____ **Weight (kg):** _____

Reason for Referral: Circumcision

Family History of Bleeding Disorder: **Y** ☐ **N** ☐

Delivery: **Term** ☐ **Pre-Term** ☐

Type of Delivery: **Natural** ☐ **C-Section** ☐

Perinatal Complications: **Y** ☐ **N** ☐

_____

_____

_____

Medications:

_____

_____

_____

Physician Name: _____ **Billing No.** _____

Physician Signature: _____