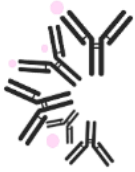


HAMILTON ALLERGY – CIRCUMCISION REFERRAL FORM



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 #: _____

Patient information:

Name: _____

Sex: **M** **F**

Date of Birth: _____

Address: _____

Home #: _____

Cell #: _____

Email: _____

Parent/Guardian Name (if applicable): _____

Health Card Number #: _____

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.

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: _____