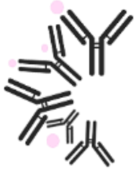
HAMILTON ALLERGY – REFERRAL FORM



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:

Urgent? ☐ **Y** ☐ **N**

Reason for Referral:

<u>**Respiratory**</u>	<u>**GI**</u>	<u>**Skin**</u>	<u>**Other**</u>
☐ Asthma	☐ GI conditions/EoE	☐ Atopic dermatitis	☐ Drug allergy
☐ Seasonal allergy	☐ Food Allergy	☐ Urticaria	☐ Circumcision
☐ Immunotherapy		☐ Contact allergy	☐ Immunodeficiency
			☐ ____________

____

____

____

____

____

____

Medications:

____

____

Physician Signature: ______________________