Address
Tel
Fax

Health PEI

PEI ALLERGY/IMMUNOLOGY
OUTPATIENT CONSULTATION REQUEST

PATIENT INFORMATION

First name: _____Last name: _____Gender: _____

Date of Birth (Day/Month/Year): _____ PHN: _____

Parent/Guardian (if applicable): _____ Relation: _____

Email: _____

Primary phone number: _____ Alternative phone number: _____

Patient address:

REFERRING PROVIDER INFORMATION

Referring physician: _____
Tel: _____ Fax: _____
Address:_____
Family Physician (if differs from referring provider): _____

For optimal triage, provide the following information (please check the appropriate one).

Suspected Diagnosis [ ] Or Confirmed Diagnosis [ ] :
[ ] Asthma. Has your patient ever been prescribed an asthma puffer (s)? yes [ ] no [ ]. Please attach PFT, if available.
[ ] Allergic rhinitis and/or conjunctivitis
[ ] Atopic Dermatitis/Eczema
[ ] Medication Allergy
[ ] Venom (Insect sting) Allergy
[ ] Food Allergy and/or Oral Immunotherapy (OIT clinic is currently in progress for children 5 and under)
Specify Food (s): _____
[ ] Anaphylaxis (Provide suspected anaphylaxis trigger if known: _____)
[ ] Chronic Urticaria
[ ] Angioedema
[ ] Primary Immunodeficiency
[ ] Other (please list):

Reason for Consultation:

Referral guidelines
-Please send any previous Allergy/Immunology records at time of referral, to optimize patient care.
-Provide detailed clinical information; referral requests with insufficient information will be returned.
-If this is an urgent consultation, please call the office to arrange to speak with the physician.
-For asthma referrals please order PFT (if appropriate) if not already completed and attach results, if available.
-Please include relevant clinical documentation such as associated bloodwork or ER visit records.
-Specify if an interpreter is required for the visit.