BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

ALLERGY CLINIC REFERRAL FORM
Fax referral to: 604-875-3653

The University of British Columbia
Department of Pediatrics
Faculty of Medicine
Division of Allergy
B.C. Children's Hospital
4480 Oak Street, Room 1C31 B
Vancouver, B.C. V6H 3V4
Tel: 604-875-2118 Fax: 604-875-3653
Toll Free: 1-888-300-3088 ext 2118

PATIENT INFORMATION

Patient name: _____ Gender: _____

DOB: _____ PHN: _____
(Day/Month/Year)

Home #: _____ Cell #: _____ Work #: _____

Address: _____

REFERRING PHYSICIAN INFORMATION

Referring physician: _____ Billing #:_____

Tel: _____ Fax: _____

Address: _____

So that we can organize our clinic optimally, please provide the following information *(please check appropriate one):*

SUSPECTED DIAGNOSIS [ ] OR CONFIRMED DIAGNOSIS [ ] OF

[ ] Asthma *Has your patient ever been prescribed an asthma puffer(s)?* yes **[ ]** no **[ ]**
[ ] Continuous URI
[ ] Rhino conjunctivitis/sinusitis
[ ] Eczema
[ ] Medication Allergy
[ ] Insect Allergy
[ ] Food Allergy
[ ] Anaphylaxis
[ ] Other (*please list*)

Additional Remarks: