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:

Your office will receive confirmation via fax that patient has been placed on our wait list. We book appointments directly with the family. If you want your patient seen urgently, please contact physician.