KINGSTON PEDIATRIC ALLERGY

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REQUEST FOR PEDIATRIC ALLERGY/IMMUNOLOGY CONSULTATION:

PLEASE FAX COMPLETED REFERRAL FORM TO: 613-507-7006

PLEASE SELECT WHICH PHYSICIAN THE REFERRAL IS FOR:

DR. WILLA LIAO
DR. EMILY KAY

PATIENT INFORMATION:

Name: ____________________
Gender: ____________________
Date of Birth (YY/MM/DD): ____________________
Health Card #: ____________________
Address: ____________________
____
Primary phone: ____________________
Alternative phone: ____________________

REFERRING PHYSICIAN INFORMATION:

Name: ____________________
OHIP Billing #: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Date of request:

Urgency of consultation:

Routine

Urgent (please specify reason below)

Reason(s) for consultation (please check all that apply):

Food allergy
Rhinitis/conjunctivitis/sinusitis
Asthma
Eczema
Hives/Swelling
Medication allergy
Vaccine allergy
Insect allergy
Immunodeficiency
Other (please describe below)

Brief description of problem(s) and question(s):

Other significant medical history:

Medications:

Your office will receive a fax confirmation that your patient has been scheduled for an appointment. We will also notify the family directly.