ACIR
Allergy Clinical Immunology Rheumatology

Aurora-Newmarket Family Health Team
531 Davis Dr, Newmarket, ON L3Y 6P5
(905) 898-2240

FAX REFERRAL TO:
905-898-2253

Date: _____

☐ **Urgent** ☐ **Pregnant** ☐ **2 years old & older**

Reason for Referral *(check all that apply)*:

☐ Allergic Rhinitis	☐ Penicillin Allergy	☐ Allergy Injections
☐ Asthma	☐ Eczema/atopy	☐ Angioedema
☐ Food Allergy	☐ Chronic Itchiness	☐ Other (specify below):
☐ Environmental Allergy	☐ Urticaria	_____
☐ Seasonal Allergy	☐ Skin testing covered by OHIP	_____

Clinical Information

Medication List

Patient Information:

Patients will be contacted directly. Please ensure patient healthcard is valid and contact number is in service.

First Name: Last Name: DOB: DD/MM/YYYY

Healthcard Number: Version Code: Gender: ☐ M ☐ F

Address: Phone: Cell:

Preferred Language: **Email:**

Referring Physician:

Doctor's Name	**Phone:**	**Fax:**
Address:		
Signature:	**OHIP #:**	
CC:		

IMPORTANT INFORMATION FOR PATIENTS:

The patient must discontinue all antihistamines, including Gravol, 5-days before the appointment for allergy skin testing. Inhalers and nose sprays do not affect testing. We will contact the patient directly with their appointment date and time.