



Patient Referral Form

Fax to: 517.349.5882

Patient Information:

Name:

Date of Birth:

Parent/Guardian Name:

Cell #:

Insurance:

Referring Physician Information:

Physician's Name:

Practice Contact's Name:

Office Phone:

Office Fax:

Reason for Referral: (Please check the reason and supply supporting documentation)

Allergic Rhinitis

- Repetitive sneezing
- Postnasal drip
- Congestion
- Itchy eyes, ears, nose, throat
- Wheezing Runny nose
- Sore throat Eye tearing

Patch Testing

- NAC80 Dental Metal

Drug Sensitivity/Allergic Reaction

- Antibiotic
- Local Anesthetic
- Specified Drug:

Allergy

- Food, specify
- Animals, specify
- Environmental, specify

Eosinophilic Esophagitis

- Endoscopy results, please send results
- Treatments, specify:

Anaphylaxis

- Related to environmental exposure
- Related to food exposure
- Related to medication exposure
- Unknown

Recurrent Infections

- Sinus Ears Lungs
- Frequency:

Asthma

- History of flares related to environment
- Frequent use of oral corticosteroids
- Needs lung function assessment

Stinging Insect Sensitivity

- Venom (wasp, bee)
- Type of insect:

Urticaria

- Exercise-induced Cholinergic Unknown

Atopic Dermatitis

- Area of body affected (face, arms, etc.)
- Age of onset: Frequency:
- Degree of Severity:

Other reason/comments:

PLEASE SEND DEMOGRAPHIC SHEET