DR. VIPUL JAIN MBBS, FRCPC
Allergy, Clinical Immunology
Special Interest in Skin Immunology
(Adult and Pediatrics)

DR. DANIEL LI MD, FRCPC
Allergy, Clinical Immunology
(Adult and Pediatrics)

❑ **1st Available Allergist** — or — SPECIFY PHYSICIAN: ❑ Dr. Jain ❑ Dr. Li

ALLERGY, ASTHMA & CLINICAL IMMUNOLOGY

Please check all that apply: Does the patient smoke? ❑ No ❑ Yes

__ allergic rhinitis
__ asthma
__ food allergy
__ venom allergy
__ punch biopsy
__ contact dermatitis

__ atopic dermatitis/eczema
__ urticaria /angioedema
__ psoriasis
__ pruritis/itch
__ anaphylaxis
__ warts

__ penicillin, NSAID or other drug allergy
__ eosinophilic esophagitis
__ occupational allergy (cosmetics, fragrance, metals, rubbers, etc.)
__ Other (please specify below)

Reason for referral / diagnosis: ____________________

____

Current Medications (List or attach): ____________________

____

Investigations requested:
__ spirometry
__ venom testing
__ skin prick testing for food or environmental allergies
__ penicillin skin testing
__ oral food or drug challenge
__ patch testing for allergic contact dermatitis

****Important:** All patients that require skin testings must discontinue their antihistamine medications and Gravol 4 days prior to scheduled appointment. Puffers and nose sprays do not affect testing and can be continued as prescribed. Your patient will be informed of this when we call to book their appointment.

PATIENT INFORMATION - PLEASE COMPLETE

Patient's Last Name:	First:	❑ Mr. ❑ Mrs. ❑ Ms.
Home Address:	City:	Postal Code:
Email Address:	Home Phone:	Mobile Phone:
Date of Birth:	OHIP Number:	

*We offer on site immunotherapy injections.
** **Please note:** We do not accept referrals for cosmetic procedures, cutaneous malignancies, skin surveillance, hair or nail disorders.

REFERRING PHYSICIAN - PLEASE COMPLETE

Referring Physician (PRINT) ____________________
Address: ____________________
Physician Signature: ____________________
Billing Number: ____________________

Backline Number: ____________________
Fax Number: ____________________
CC to Family Doctor (if different): ____________________
Family Doctor Phone: ____________________

Please Note: Our office will contact your patient with an appointment date and time.
Call if you would like any information at anytime at the number below.
All consult notes will be sent to your office via fax after each patient visit.

PLEASE FAX ALL REFERRALS TO: 905-371-9090 Phone: 905-357-1661
8279 Lundy's Lane, Unit A3-A4, Niagara Falls L2H 1H5