ALLERGY HUB

REFERRAL FORM

PLEASE FAX TO: 416-410-0815

PATIENT INFORMATION

Patient Full Name :

Health Card Number : **VC** :

Date of Birth (D/M/Y) : DD / MM / YYYY

Email :

Phone Number :

PHYSICIAN INFORMATION

Referring Physician :

Address :

Phone Number :

Fax Number :

Billing Number :

Date of Referral (D/M/Y) : DD / MM / YYYY

REASON FOR REFERRAL

Reason :

- ☐ Allergic Rhinitis
- ☐ Asthma
- ☐ Anaphylaxis
- ☐ Drug Allergy (Specify Drug):
- ☐ Food Allergy
- ☐ Hives/Angioedema
- ☐ Venom Allergy
- ☐ Other (specify):

Referring Physician Signature

5 Fairview Mall Drive, Suite 260, North York

416-410-0815 (Fax)

416-410-0805 (Phone)

www.allergyhub.ca

THANK YOU!