Health Plus
MULTISPECIALTY MEDICAL CLINIC

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Appointment Date: _______________Time: _______

ALLERGY & PULMONARY CLINIC REFERRAL

PATIENT INFORMATION			
Patient's Last Name:	First Name:	Middle Name:	Sex: ❑ M ❑ F
Date of Birth:	OHIP no:		Version Code:
Patient's Address:			
City:		Province:	Postal Code:
Home Phone no:		Mobile Phone no:	

REASON FOR REFERRAL		
ALLERGY	☐ Food Allergy ☐ Allergy Rhinitis ☐ Allergies, unspecified ☐ Atopic Dermatitis	☐ Cough ☐ Wheezing ☐ Asthma ☐ Other (Specify) ______________________________
PULMONARY	☐ Wheezing ☐ Reactive Airway Disease ☐ Asthma (Non-Allergy Related)	☐ Exercise Induced Asthma ☐ Other (Specify) ______________________________
DIAGNOSIS		

REFERRAL INFORMATION	
Referring Physician:	Date:
Physician Signature:	Billing no: