Dr. Sophia Xu
Allergist MD, FRCPC

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Referral Form

Referring Physician or Nurse Information

Date (MM/DD/YY) | Name | Billing Number

Address | Phone | Fax

Signature | Family Doctor (If different)

Patient Information

Name | DOB (MM/DD/YY) | Sex ☐ M ☐ F

Health Card (Version code if applicable) | Address

Preferred Phone No. | Alternate Number

Email

Reason For Referral ☐ Routine ☐ Rapid Clinic (Patients offered an appointment within 5 business days)

- ☐ Food allergy
- ☐ Anaphylaxis
- ☐ Hives/angioedema
- ☐ Eczema
- ☐ Contact dermatitis
- ☐ Other rash
- ☐ Asthma/Query asthma
- ☐ Cough
- ☐ Rhinitis
- ☐ Conjunctivitis
- ☐ Infant food introduction
- ☐ Medication allergy
- ☐ Spirometry
- ☐ Patch testing
- ☐ Biological therapy
- ☐ Small molecule therapy
- ☐ Other

Additional Details (Optional)

Medical History and Current Medications (You may attach separately if preferred)

Please note referrals with multiple unrelated issues will be considered separate referrals, unless indicated otherwise.