Centre for Antibiotic Allergy and Research Clinic Referral Form

Name: _____

DOB: _____ **Male** ☐ **Female** ☐

UR: _____ **Patient phone number:** _____

Referring hospital: _____ **Referring unit:** _____

Referring clinician: _____ **Clinician provider number:** _____

Current or future antibiotic therapy affected by antibiotic allergy? **Yes** ☐ **No** ☐

Past medical history (please list)**:**

Current medications (please list)**:**

Antibiotic allergy history *(including perioperative drug allergy - Austin only)*

Drug (1): _____ Reaction: _____

Drug (2): _____ Reaction: _____

Drug (3): _____ Reaction: _____

Drug (4): _____ Reaction: _____

Drug (5): _____ Reaction: _____

Please forward referral to either (A) Austin Health OR (B) PMCC for clinic appointment:

A. **Austin Health Infectious Diseases Antibiotic Allergy Clinic (IDAC)** *[for perioperative drug allergy also]*
FAX: (03) 94966677 OR via **Email:** antibiotic.allergy@austin.org.au | Phone (for advice): (03) 94964572

B. **Victorian Comprehensive Cancer Centre - Peter MaCallum Cancer Centre Antibiotic Allergy Clinic**
FAX: (03) 85597999 OR via **Email:** Jason.trubiano@petermac.org | Phone (for advice): (03) 8559 7560

to Austin

to PMCC

Centre for Antibiotic Allergy and Research
Optimising antibiotic therapy