

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):

[Empty box for past medical history]

[Empty box for current medications]

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 MacCallum Cancer Centre Antibiotic Allergy Clinic
FAX: (03) 85597999 OR via Email: Jason.trubiano@petermac.org | Phone (for advice): (03) 8559 7560

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