REFERRAL FORM

CENTRAL ALLERGY AND ASTHMA CLINIC **DR.PRIYANKA LALL**
230-157 QUEEN STREET E, BRAMPTON

☐ **Urgent** ☐ **Routine**

Name: _____ **DOB:** _____

Phone #: _____ **Health Card #:** _____

Address: _____ **Email:** _____

Referring Physician: _____ **OHIP Billing #:** _____

Physician Contact #: _____ **Physician Fax #:** _____

Reason for Referral

☐ **Rhinitis**	☐ **Eczema**
☐ **Asthma**	☐ **Food Allergies**
☐ **Stinging Insect Allergy**	☐ **Urticaria/Angioedema**
☐ **Drug Allergy**	☐ **Anaphylaxis**

Additional Information:

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