ALLERGY/IMMUNOLOGY REFERRAL FORM

Dr. Samuel Yung, MD, FRPCP
17730 Leslie St
NEWMARKET, Ontario L3Y 8E4
Tel: 905-853-0404
Fax: 905-853-3702

☐ ROUTINE ☐ URGENT

Patient name & demographics (including OHIP #):

Referring physician information and OHIP #:

Reason(s) for referral (check all that apply):

- ☐ Allergic rhinitis
- ☐ Food allergy
- ☐ Asthma
- ☐ Anaphylaxis NYD
- ☐ Urticaria and/or angioedema
- ☐ Recurrent infections/immunodeficiency
- ☐ Drug allergy
- ☐ Eczema
- ☐ Other (please specify below)

Clinical description:

*Please attach medication list if available **Signature** _____

PLEASE FAX REFERRALS TO: 905-853-3702