



Dr. Saba Merchant, MD, FRCPC
& Associates

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RCPSC Allergy and Clinical Immunology trained

Allergy and Immunology Referral Form - Adult and Pediatric

☐ Routine

☐ Urgent

Patient information:

Name: _____ **DOB:** _____

Address: _____

Health card: _____

Phone number: _____ **Cell number:** _____

Email Address: _____

Referring Physician:

Name: _____

Address: _____

Billing number: _____

Phone number: _____

Fax number: _____

Reason for referral:

☐ Allergic Rhinitis

☐ Anaphylaxis

☐ Asthma

☐ Drug allergy (e.g. Penicillin)

☐ Eczema/Atopic Dermatitis

☐ Eosinophilic Esophagitis

☐ Immunodeficiency

☐ Food allergy

☐ Latex allergy

☐ Stinging Insect allergy

☐ Urticaria/Angioedema

☐ Other

Referral Details:

Please fax referral to: 905-303-3035
110-955 Major Mackenzie Drive West Maple, ON L6A 4P9