St. Joseph's Healthcare Hamilton | FIRH Firestone Institute for Respiratory Health | McMaster University

Adverse Reactions Clinic
REQUISITION FORM

Charlton Campus, Juravinski Tower, Level 1
50 Charlton Ave., East
Hamilton, ON, Canada L8N 4A6
Tel: 905.521.6000 Fax: 905.523.(LUNG).5864
Dial Direct: 905.522.1155 ext. 35210

J. Greenbaum, MD, FRCPC
P.K. Keith, MD, MSc, FRCPC
S. Waserman, MDCM, MSc, FRCPC

Surname: _____ First: _____

Address: _____

_____

_____

Home Telephone: _____

Work Telephone: _____

Cell phone: _____

Birth Date (yyyy/mm/dd): _____ Sex: M ☐ F ☐

Family Physician: _____

Referring Physician: _____

HC#: _____ Version: _____

Please inform your patient in the event that skin testing is required, they should discontinue their antihistamine medications and Gravol 4 days prior to their scheduled appointment. Puffers and nose sprays do not affect testing, and can be continued as prescribed. Appointment may take 2-3 hours. Thank you.

Appointment Date: (yyyy/mm/dd) _____ **Time:** (hh:mm) _____

Please specify the type of assessment requested and the reason for referral.

_____

_____

_____

Antibiotics:

Penicillin _____

Other *(Please Specify)* _____

Medication: (please specify) _____

Local Anaesthetic Testing _____

General Anaesthetic Testing _____

(Please send a copy of the anaesthetic record prior to appointment)

Vaccines: *(please specify)* _____

Food: *(please specify)* _____

Insect Venom: _____

Latex allery: _____

Environmental: _____ **Other:** _____

Requesting Physician Signature:	**OHIP Billing #:**	**Fax:**
Family Physician (if different than requesting physician):		**Date:** (yyyy/mm/dd)