



E-mail: referral@med1.ca

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<p>Allergy Rapid Access Clinic (RAC)</p> <p>Reason for referral (check <u>ALL</u> that apply):</p> <table border="0"> <tr> <td><input type="checkbox"/> Hives/Rash</td> <td><input type="checkbox"/> Anaphylaxis</td> </tr> <tr> <td><input type="checkbox"/> Rhinitis / Congestion</td> <td><input type="checkbox"/> Penicillin/Drug Allergy</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Immunotherapy</td> </tr> <tr> <td><input type="checkbox"/> Eczema</td> <td><input type="checkbox"/> Stinging Insect Allergy</td> </tr> <tr> <td><input type="checkbox"/> Food Allergy</td> <td><input type="checkbox"/> Immunodeficiency</td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td></td> </tr> </table>		<input type="checkbox"/> Hives/Rash	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Rhinitis / Congestion	<input type="checkbox"/> Penicillin/Drug Allergy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Immunotherapy	<input type="checkbox"/> Eczema	<input type="checkbox"/> Stinging Insect Allergy	<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Immunodeficiency	<input type="checkbox"/> Other:		<p>IV Iron Infusion with Internal Medicine Consultation</p> <p><input type="checkbox"/> Routine</p> <p><input type="checkbox"/> Urgent Hemoglobin: Ferritin:</p> <p>Includes Rapid GIM Consult to assess for IV Iron Infusion Eligibility. Infusions performed in a fully equipped, state-of-the-art medical facility with Internal Medicine specialist present on site during the infusion. Infusion administration fee is not covered by OHIP.</p>
<input type="checkbox"/> Hives/Rash	<input type="checkbox"/> Anaphylaxis													
<input type="checkbox"/> Rhinitis / Congestion	<input type="checkbox"/> Penicillin/Drug Allergy													
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<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Immunodeficiency													
<input type="checkbox"/> Other:														
<p>Chronic Cough Clinic (CCC)</p> <p><input type="checkbox"/> Cough > 8 weeks</p>	<p><input type="checkbox"/> General Pediatric Clinic</p> <p>Reason for referral:</p>													

Last name:			First name:			Sex:		
Address:			City:			Postal code:		
E-mail:			Phone Number(s):					
Date of Birth:			OHIP:					

Referring physician (full name):		Fax number:	
Family doctor (if different):		Billing number:	

Please fax referrals to **647-714-5199** or e-mail at **referral@med1.ca**.
If you need EMR-compatible files or physical referral pads for your clinic, please e-mail us.