Sunnybrook
HEALTH SCIENCES CENTRE

TO AVOID DELAY PLEASE COMPLETE ALL SECTIONS

Drug Allergy Clinic Referral Form
2075 Bayview Avenue
M4N3M5, Toronto Ontario
Office: UG-0A, Desk 4
Clinic: K-Wing, 3rd Floor
Phone: 416-480-6100 x3271
Fax: 416-480-5229
Email: drugsafety@sunnybrook.ca

Dr. Y Moolani Merchant, MD, FRCPC **Dr. L Fu, MD, FRCPC** **Dr. E Lee, MD, FRCPC**

Date of Referral: _____ **Patient Name:** _____

DOB (YY/MM/DD): _____ **Sex:** _____ **Health Card #:** _____ **Version Code:** _____

Address: _____

Telephone: Primary: _____ **Secondary:** _____ **Other:** _____

Emergency Contact Name: _____ **Telephone:** _____

Referring Doctor: _____ **OHIP Billing:** _____

Address: _____

Telephone: _____ **Fax:** _____

Family Doctor: _____ **OHIP Billing:** _____

Address: _____

Telephone: _____ **Fax:** _____

Date of Reaction Onset (YY/MM/DD) _____

Medications, Please Specify:
Describe Allergic Reaction/Event/Date/Timing– include date of reaction and timing in relation to medications:
Additional information – Further details, laboratory values, treatment of reaction/outcome:
Is this referral urgent? Provide details: