Abbeydale Medical Clinic

Dr. Marius Conradie, MD

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Allergy Testing Referral Form

Patient Information

Name: _____

Date of Birth: _____

PHN: _____

Phone: _____

Email: _____

Address: _____

Referring Physician Information

Physician Name: _____

PRACID: _____

Clinic Name: _____

Phone: _____

Fax: _____

Reason for Referral

[ ] Allergic Rhinitis (Hay Fever)

[ ] Asthma

[ ] Food Allergies

[ ] Drug Allergies

[ ] Eczema/Atopic Dermatitis

[ ] Contact Dermatitis

[ ] Chronic Urticaria (Hives)

[ ] Other: _____

Relevant Medical History

[ ] Previous Allergy Testing: Yes / No

[ ] Current Medications: _____

[ ] Additional Notes: _____