UB|MD PEDIATRICS

# NEW PATIENT REFERRAL FORM

Patient Name: _____ DOB: _____/_____/_____

Referring Provider: _____

PMD (if different than above): _____

Phone: _____ Fax: _____

**Reason for Referral:**

- ☐ Asthma
- ☐ Allergic Rhinitis
- ☐ Eczema
- ☐ Chronic Urticaria
- ☐ Food Allergy
- ☐ Venom Allergy
- ☐ Suspected Immune Deficiency
- ☐ Other: _____

**Details of Referral:**

*Please attach all pertinent clinic notes, laboratory testing and imaging results.

*Please see the patient:

- ☐ ASAP
- ☐ Next available appointment

**Please complete this form and fax it back to our office at 716.323.0296.** Be sure to include all recent lab work and other testing. Please allow three business days for a new appointment to be scheduled for your patient.

**If you need to reach our office, please call 716.323.0130. Thank you for your referral.**

Division of Allergy/Immunology
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