NL Allergy
& Immunology
Specialist Physicians in Allergy
& Clinical Immunology

REQUEST FOR CONSULTATION

Fax referral to: 709-726-6634

2 Mount Cashel Road
St. John's, NL, A1A 1X7
Phone: (709)726-7552

Patient Information

First Name: ______________________________ Last Name: ______________________________

Date of Birth: __________________________ MCP: __________________________________

Parent/Guardian (if applicable): _________________________ Relation: ________________________

Email: ______________________________

Primary phone number: _____________________________ Home [ ] Cell [ ]

Mailing Address: ____

Referring Provider Information

First Name: _____________________________ Last Name: ____________________________

Fax Number: ____________________________

Referral guidelines:

- Please provide detailed clinical information; referrals with insufficient information will be returned.
- If this is an urgent consultation, please call our office to arrange to speak with a physician.
- Please include any relevant clinical documentation such as ER visit records.
- For asthma referrals: please order PFT if not already completed and attach results if available.

Reason for Consultation: