

Date: [Date]

To: [Specialist Name/Clinic Name]

Department: Allergy and Immunology

Address: [Specialist Address]

RE: Referral for Initial Allergy and Immunology Testing

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient Phone: [Phone Number]

Dear Dr. [Specialist Last Name],

I am writing to refer [Patient Name] for an initial consultation and diagnostic testing regarding [specific concern, e.g., suspected food allergies, seasonal rhinitis, or chronic urticaria].

Clinical History:

The patient has been experiencing the following symptoms: [List symptoms]. These symptoms first appeared on [Date/Timeframe] and occur with a frequency of [Frequency].

Suspected Triggers:

[List suspected allergens, e.g., peanuts, dust mites, latex, etc.]

Current Medications:

[List medications, specifically noting any antihistamine use]

Relevant Medical History:

[List comorbid conditions, e.g., asthma, eczema, or previous anaphylaxis]

I would appreciate your specialist evaluation and any indicated skin prick testing or IgE blood panels to assist in the management of this patient. Please find the attached relevant clinical notes and previous laboratory results.

Thank you for your assistance in this matter.

Sincerely,

[Referring Physician Signature]

[Referring Physician Name]

[Clinic Name]

[Contact Information]