Date: [Date]

To: [Specialist Name, MD/DO]
Department of Pediatric Allergy and Immunology
[Clinic/Hospital Name]
[Address]

RE: Consultation Request for [Patient Full Name]
Date of Birth: [Patient DOB]
Parent/Guardian Name: [Guardian Name]

Dear Dr. [Specialist Last Name],

I am writing to formally request a consultation and diagnostic testing for the above-named patient due to the following clinical concerns:

- [List primary symptoms, e.g., chronic urticaria, respiratory distress, or GI issues]
- [List suspected triggers, e.g., specific foods, environmental factors, or medications]
- [Duration and frequency of symptoms]

Current medications and interventions: [List medications, e.g., antihistamines, topical steroids]

Specifically, I am requesting that the patient be evaluated for:

- [ ] Skin Prick Testing (SPT)
- [ ] Serum IgE Testing (Radioallergosorbent test)
- [ ] Oral Food Challenge (OFC)
- [ ] Pulmonary Function Testing (if applicable)

Included with this letter are the patient's relevant medical records, growth charts, and recent lab results. Please contact our office if you require additional information prior to the appointment.

Thank you for your assistance in the care of this patient.

Sincerely,

[Referring Physician Signature]
[Referring Physician Name]
[Practice Name]
[Phone Number]
[Fax Number]