

Date: [Date]

To: [Consultant Name]  
Department of Allergy and Immunology  
[Hospital/Clinic Name]  
[Address]

Re: [Patient Full Name]  
DOB: [Date of Birth]  
Address: [Patient Address]

Dear Dr. [Consultant Last Name],

I am referring this patient for a comprehensive allergy and immunology evaluation due to [suspected food allergies / recurrent allergic reactions].

**Clinical History:**

[Describe specific reactions, including timeline, symptoms such as urticaria, angioedema, or respiratory distress, and suspected triggers].

**Current Medications:**

[List medications, including antihistamines or epinephrine auto-injectors].

**Requested Evaluation:**

I request your expertise in performing and interpreting the following tests as clinically indicated:

- Skin Prick Testing (SPT) for [Specific Food Panels]
- Serum IgE Allergy Testing (sIgE)
- Component-Resolved Diagnostics (CRD)
- Baseline Serum Tryptase levels
- Evaluation for Oral Food Challenge (OFC) eligibility
- Assessment of underlying immunologic markers

**Management Goals:**

The goal of this consultation is to confirm specific allergens, assess the risk of anaphylaxis, and establish a comprehensive long-term management and emergency action plan.

Thank you for your assistance with this patient's care. Please forward a copy of your consultation report and test results to my office.

Sincerely,

[Your Signature]  
[Your Printed Name]  
[Your Professional Title]  
[Clinic Name/Contact Information]