Date: [Insert Date]

To: [Specialist Name, MD/DO]
Department: Allergy and Immunology
Facility: [Facility Name]
Address: [Facility Address]

RE: Referral for Drug Allergy and Immunology Testing
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Insurance ID: [Insurance Number]

Dear Dr. [Specialist Last Name],

I am referring this patient to your clinic for a comprehensive evaluation and diagnostic testing regarding a suspected drug allergy.

Suspected Allergen(s): [List Medications, e.g., Penicillin, NSAIDs, Contrast Dye]

Clinical History:
[Briefly describe the reaction, e.g., "The patient developed a maculopapular rash and facial swelling 30 minutes after ingestion on (Date)."]

Current Medical Status:
[Briefly mention comorbidities or relevant medications, e.g., "Patient is currently managed for hypertension and asthma."]

Reason for Consultation:
The patient requires [Select: Skin Prick Testing / Intradermal Testing / Graded Challenge / Desensitization] to confirm the allergy and determine safe therapeutic alternatives for future treatment.

Please find the patient's recent clinical notes and medication list attached. We look forward to your specialist recommendations.

Sincerely,

[Referring Physician Name]
[Clinic Name]
[Phone Number]
[Fax Number]