**Date:** [Date of Consultation]

**RE:** [Patient Name]
**DOB:** [Date of Birth]
**Address:** [Patient Address]

**Referring Physician:** [Referring Doctor Name]
**Consulting Physician:** [Consultant Name]

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**Reason for Consultation:** [e.g., Seasonal Rhinitis, Suspected Food Allergy, Chronic Urticaria]

**Clinical History:**
[Insert brief summary of patient symptoms, duration, triggers, and previous treatments tried.]

**Allergy Testing Results:**

- **Skin Prick Testing:** [List allergens and wheal/flare size, or "Negative"]
- **Serum IgE / RAST Testing:** [List specific IgE levels if applicable]
- **Patch Testing:** [Results if applicable]
- **Spirometry/Lung Function:** [Results if applicable]

**Assessment:**
[Diagnosis or clinical impression based on history and test results.]

**Plan and Recommendations:**

1. **Avoidance Measures:** [List specific environmental or dietary triggers to avoid]
2. **Pharmacotherapy:** [List prescribed antihistamines, nasal sprays, or inhalers]
3. **Emergency Preparedness:** [Mention if Epinephrine Auto-Injector was prescribed and training provided]
4. **Immunotherapy:** [Recommendations for allergy shots or sublingual tablets, if applicable]
5. **Follow-up:** [Timeline for next appointment]

Thank you for involving us in the care of this patient.

Sincerely,

[Signature]
[Consultant Name and Title]
[Clinic Name/Department]