Date: [Insert Date]

To: [Specialist Name/Allergy Department]
Clinic Name: [Insert Clinic Name]
Address: [Insert Clinic Address]

RE: Referral for Allergic Reaction Evaluation

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Contact Number: [Insert Phone Number]

Dear Dr. [Specialist Last Name],

I am referring this patient for an urgent specialist evaluation following a suspected allergic reaction to a vaccination.

Vaccination Details:
- Vaccine Type/Brand: [Insert Vaccine Name]
- Dose Number: [e.g., 1st dose, 2nd dose, booster]
- Date of Administration: [Insert Date]
- Time of Administration: [Insert Time]

Reaction Details:
- Time of Onset: [e.g., 15 minutes post-injection]
- Symptoms: [e.g., Urticaria, angioedema, respiratory distress, hypotension]
- Treatment Administered: [e.g., Epinephrine, Antihistamines, Steroids]
- Clinical Outcome: [e.g., Resolved in ER, Ongoing symptoms]

Relevant Medical History:
- Known Allergies: [Insert Allergies]
- Current Medications: [Insert Medications]

Purpose of Referral:
Please assess this patient for vaccine component hypersensitivity. We request your guidance on the safety of future doses and recommendations for alternative vaccination protocols.

I have attached the patient's vaccination record and clinical notes from the acute event for your review.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Organization]
[Contact Information]