FOOD ALLERGY CENTER PATIENT REFERRAL

FAX: 214-456-8317

Physician: ______________J. Andrew Bird, M.D.__________________

PATIENT INFORMATION			
Name:		**CMCD MR# (if applicable):**	
Address (include city, state, zip):			
DOB:	☐ Male ☐ Female	**Language** ☐ English ☐ Spanish ☐ Other	
Primary Diagnosis	☐ Allergic rhinitis	☐ Food allergies	☐ Allergies, unspecified
	☐ Atopic Dermatitis	☐ other _______________	
Secondary Diagnosis	☐ Asthma	☐ Wheezing	☐ Cough

☐ Other:

REASON FOR REFERRAL/ SPECIFIC QUESTION TO BE ANSWERED:

Please fax all records (including immunization record, growth chart, ImmunoCAP, RAST or any other allergy testing, other labs, visit notes, etc.)

PARENT/GUARDIAN INFORMATION		
Name:		**Relationship:** ☐ **Mother** ☐ **Father** ☐ **Other (specify)**
Address (if different than patient's):		
Home phone:	**Work phone**	**Cell phone:**

REFERRING PHYSICIAN INFORMATION		
Name:	**Specialty:**	
Address (include street, city, state and zip):		
Contact Person:	**Phone:**	**Fax:**

Please fax all of the records listed above as soon as possible for our physician to review prior to the patient's scheduled appointment. Thank you!

Children's Medical Center
1935 Medical District Drive, Dallas, TX 75235
214-456-2084 214-456-8317 (fax)