



DT9426

CONSULTATION FOR ALLERGY/ IMMUNOLOGY ADULT AND PEDIATRIC

Note: Refer to the clinical alerts on the back of the form and favor, if available, the protocols of the Accueil Clinique before filling it out.

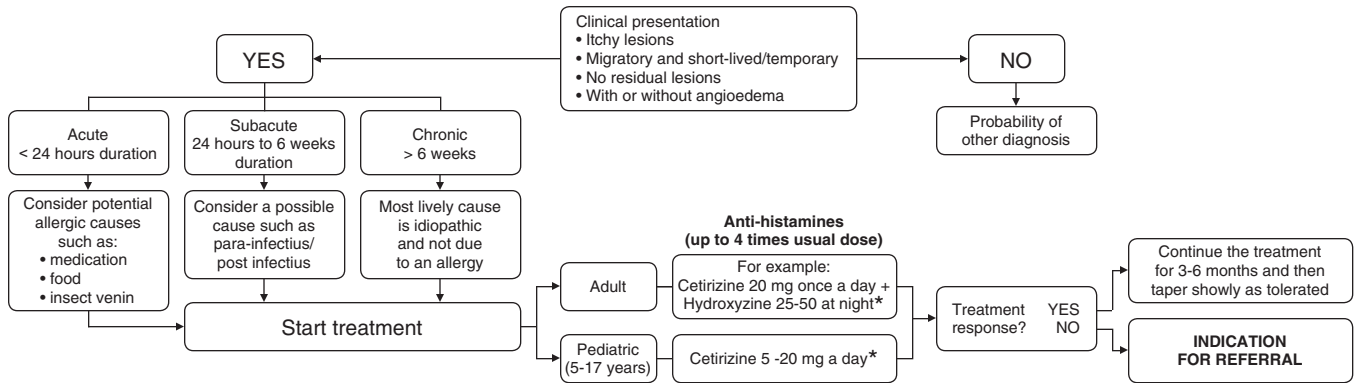
Patient's first and last name			
Health insurance number		Year	Month
		Expiry	
Parent's first and last name			
Area code	Phone number	Area code	Phone number (alt.)
Address			
Postal code			

Reason for consultation		Clinical priority scale: A: ≤ 3 days B: ≤ 10 days C: ≤ 28 days D: ≤ 3 months E: ≤ 12 months						
Respiratory	Rhinitis/ recurrent sinusitis	<input type="checkbox"/> Evaluation and treatment options	E	Urticaria/ Angioedema ²	<input type="checkbox"/> Chronic urticaria ² > 6 weeks (with or without angioedema) not controlled with 4 times the dose of a non sedating 2 nd generation antihistamine	D		
		<input type="checkbox"/> Allergy evaluation/skin tests	E		For acute urticaria: please refer to the chart ² on the back of this form or other sections of the form			
		<input type="checkbox"/> Evaluate if a candidate for desensitization for inhalent allergies	E					
	Asthma	<input type="checkbox"/> Evaluation and treatment options	E		Immuno- deficiency	Suspected immunodeficiency ⁴ (Prerequisite: CBC, IgG, IgA, IgM)	<input type="checkbox"/> If IgG level is abnormal	D
		<input type="checkbox"/> Allergy evaluation/skin tests	E				<input type="checkbox"/> ≥ 2 episodes of isolated angioedema ² despite already stopping ACE inhibitors ³	D
		<input type="checkbox"/> Evaluate if a candidate for desensitization for inhalent allergies	E				<input type="checkbox"/> If IgG level is normal	E
Food allergy	Food allergy ¹ (please specify the suspected food or foods) *Prescribe an epinephrine auto injector	Age < 2 yrs <input type="checkbox"/> ≥ 2 foods <input type="checkbox"/> Only one food	D E	Medication	(Prerequisite: must specify which medication or medications and give details about the reaction in the section "Relevant clinical information")	<input type="checkbox"/> Penicillin ⁵	E	
		Age ≥ 2 yrs <input type="checkbox"/> ≥ 2 episodes in the last year <input type="checkbox"/> First episode	D C			<input type="checkbox"/> Other medications ⁵	E	
Anaphylaxis	Anaphylaxis ¹ of unknown cause *Prescribe an epinephrine auto injector Diagnostic criteria for anaphylaxis: ≥ 2 systems involved (please specify): • Skin involvement including angioedema • Respiratory system • Gastrointestinal system • Cardiovascular system		D	Vaccines	Vaccin allergy: Complete the formulary "Déclaration de manifestations cliniques après une vaccination" ⁶ and send it to the Director of Public Health. Do not refer to the CRDS.	<input type="checkbox"/> Essential medication without alternatives ⁵ AND need to be prescribed in a short time (specify)	C	
	Anaphylaxis ¹ with a known cause, please refer to other sections on this form							
	<input type="checkbox"/> Insect allergies with systemic reactions *Prescribe an epinephrine auto injector		D					
<input type="checkbox"/> Other reason for consultation or clinical priority modification (MANDATORY justification in the next section):						Clinical priority		
Suspected diagnosis and clinical information (mandatory)					If prerequisite is needed :			
					<input type="checkbox"/> Available in the QHR			
					<input type="checkbox"/> Attached to this form			
Special needs:								
Referring physician identification and point of service					Stamp			
Referring physician's name				Licence no.				
Area code Phone no.		Extension		Area code Fax no.				
Name of point of service								
Signature				Date (year, month, day)				
Family physician: <input type="checkbox"/> Same as referring physician <input type="checkbox"/> Patient with no family physician					Registered referral (if required)			
Family physician's name					If you would like a referral for a particular physician or point of service			
Name of point of service								

Legend

¹ Note: There is a refractory period up to 6 weeks for test's validity (false negative) post anaphylactic reaction

² Urticaria and angioedema treatment (see chart below)



* Systemic oral steroids **are not** recommended as first line treatment for urticaria

³ ACEI: angiotensin-converting-enzyme inhibitor

⁴ Suspect immune deficiency: <http://immunodeficiency.ca/primary-immunodeficiency/10-warning-signs/>

⁵ In case of a new drug reaction, fill in the Form AH-707A (New allergic drug reaction reporting Form)

⁶ Link to declaration form: http://publications.msss.gouv.qc.ca/msss/fichiers/piq/chap7_mci-formulaire-generique.doc

Clinical alerts (non-exhaustive list)
Refer the patient to the Emergency-department
<ul style="list-style-type: none"> • Acute anaphylaxis • Severe asthma exacerbations or an asthma exacerbation unresponsive to at least 24 hours of oral steroid treatment