Appointment Request and Clinical Triage Form
Allergy/Immunology Clinic

Preferred Location: __ Texas Medical Center __ West Houston

Date of Request: ___________________________ Phone: 832-824-1319
Fax: 832-825-8987

Patient Information (Please Print)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name &amp; MI</th>
<th>Date of Birth</th>
<th>M/F</th>
</tr>
</thead>
</table>

Parent/Guardian Name(s) Preferred contact (x)  □ Home Phone #  □ Work phone #  □ Mobile #

Referring Physician Information

<table>
<thead>
<tr>
<th>Referring Physician Name (PCP and/or Subspecialist)</th>
<th>Best time to reach physician</th>
<th>Best contact number</th>
</tr>
</thead>
</table>

Practice Contact  Practice  Office Phone #  Office Fax #

Is an insurance referral needed for our office? If so, please fax to 832-825-3072.

Reason for referral: Please check the reason for referral and request all supporting documentation.

☐ Anaphylaxis
  - Related to environmental exposure
  - Related to food exposure
  - Related to medication exposure
  - Unknown

☐ Recurrent Infections
  - Sinus
  - Ears
  - Lungs
  - Other
  - Frequency

☐ Drug Sensitivity/Allergic Reaction
  - Vaccine
  - Antibiotic
  - Local Anesthetic
  - Specify Drug _____________________________

☐ Stinging insect sensitivity
  - Venom (Wasp, Bee)
  - Fire Ant
  - Type of Insect ____________________________

☐ Atopic Dermatitis
  - Area of body affected (extremities, trunk, face)
  - Age of onset _____________________________
  - Frequency, recurrence ____________________
  - Degree of Severity ________________________
  - Has the patient been referred to Dermatology? Y/N

☐ Urticaria
  - Exercise-induced
  - Cholinergic
  - Unknown
  - Has the patient been referred to Dermatology? Y/N

☐ Allergy
  - Food, Specify ____________________________
  - Animals, Specify _________________________
  - Environment, Specify _____________________

☐ Asthma
  - History of flares related to environmental exposures
  - Frequent use of oral corticosteroids
  - Needs lung function assessment
  - Has the patient been referred to Pulmonary? Y/N

☐ Eosinophilic Esophagitis
  - Endoscopy results, please send result
  - Treatments, Specify ________________________

☐ Other Reason:

☐ Allergic Rhinitis
  - Repetitive sneezing
  - Post-nasal drip
  - Itchy eyes, ears, nose or throat
  - Sore throat
  - Wheezing
  - Eye tearing

Other Reason:

Comments (type of reaction):

Diagnostic Tests/Labs/Evaluations: *Please check any of the following tests which have been completed or are scheduled to be completed. Fax or send with patient to appointment the results of tests already performed. For scheduled tests, provide upcoming schedule date(s) of test(s).

☐ Diagnostic Tests
☐ Pulmonary Function Testing
☐ Lab Tests
☐ ENT Evaluation
☐ RAST Tests (Allergy labs/blood test)
☐ Skin Test

If any of the above is checked, please fax results to 832-825-8987.

☐ Physician will fax results including:

☐ No results to fax

Has the patient been hospitalized for this medical problem?  Yes  No

If yes, date(s) and for how long. ______________________________________________________

For Office Use only

Triaged By:  □ Urgent  □ Routine  □ MRN: _____________________________

MD On-Call Notified: _____________________________ Appointment: ___________

□ Arrived  □ No Show