Patient Name:

Date Of Birth:

Phone #:

Address:

Referring Physician:

Referring Physician's Contact #:

Referring Physician's Fax #:

PAR Allergy Center

Reason For Referral

ALLERGY REFERRAL (Pediatric And Adult):

- ○ Allergic rhinitis/Hay fever
- ○ Nasal polyps
- ○ Asthma
- ○ Food allergy
- ○ Drug allergy
- ○ Atopic Dermatitis/Eczema
- ○ Eosinophilic/Esophagitis
- ○ Environmental allergies/Pet dander allergies
- ○ Hives
- ○ FPIES
- ○ Bee sting allergy
- ○ Anaphylaxis
- ○ Immunodeficiency/Recurrent Infections
- ○ Others _____

Comments:

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OUR Allergy LOCATION:

6600 West Broad Street | #300 | Richmond, VA 23230

WWW.PARACCESS.COM | (804) 320-4243

Referrals can also be faxed with the patient demographic information sheet to **804-591-3191.**