MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

OUTPATIENT CONSULT REQUEST

Send Form and Records by Fax to: 734-998-2519

Division of Allergy & Clinical Immunology
24 Frank Lloyd Wright Drive
P.O. Box 442, Suite H-2100
Ann Arbor, MI 48106
Office: 888-229-2409
Fax: 734-998-2519

Today's Date:

Patient Demographic Information

Patient Last Name:		Patient First Name:	
Street Address:	City:	State:	Zip:
Home Phone:		Cell Phone:	
Patient Sex assigned at birth:		Patient Gender:	
Main Contact Name (if not patient):		Main Contact Phone:	
Primary Insurance Company:			
Date of Birth:			

Physician Information

Referring Physician Name:			
Office Contact Name:			
Address:	City:	State:	Zip:
Phone:		Fax:	
Primary Care Physician Name (if different than referring physician):			
Address:	City:	State:	Zip:
Phone:		Fax:	

If referring to a specific provider, please note: _____

Is this referral for a 2nd opinion only (patient will return to care of referring provider after consultation)?

☐ Yes ☐ No

SELECT THE PATIENT'S PRIMARY DIAGNOSIS AND ANSWER ANY APPLICABLE QUESTIONS

Check appropriate category.

	General Allergy	*Referring Diagnosis / Comments:*
	Anaphylaxis • What caused the anaphylaxis reaction? ☐ Drug ☐ Exercise ☐ Food ☐ Other ☐ Unknown • Do you know the date of the reaction? ☐ Yes ☐ No ☐ Unknown Date, if known: _____ • Is this referral for an upcoming surgery or procedure? ☐ Yes ☐ No ☐ Unknown	
	Asthma • Patient has had an emergency room visit or hospitalization related to asthma in the past 12 months: ☐ Yes ☐ No ☐ Unknown • Patient requires maintenance oral corticosteroids (OCS) or had 2 or more exacerbations in the past 12 months: ☐ Yes ☐ No ☐ Unknown • Patient is currently using biologic therapy for asthma or is referral for consideration of biologic therapy: ☐ Yes ☐ No ☐ Unknown • Patient is still symptomatic despite inhaled corticosteroid (ICS)/long-acting beta agonist (LABA): ☐ Yes ☐ No ☐ Unknown	
	Atopic Dermatitis / Eczema	*Comments:*
	Contact Dermatitis • Due to? ☐ Cosmetics, Drugs/Meds, Chemicals, Plants ☐ Metals ☐ Sunscreen ☐ Other ☐ Unknown • Is this referral for an upcoming surgery or procedure? ☐ Yes ☐ No ☐ Unknown	
	Eosinophilic Esophagitis (EOE)	*Comments:* *Patient must have a biopsy-confirmed diagnosis of EOE within 3 years.*
	Food Allergy ☐ Food Allergy ☐ Milk / Soy Protein Intolerance ☐ Oral Allergy Syndrome ☐ Other Food Intolerances	
	FPIES	*Comments:*
	Immunodeficiency ☐ CVID ☐ DiGeorge Syndrome ☐ Hypogammaglobulinemia ☐ Low Antibody Levels ☐ Low Vaccine Titers ☐ Primary ☐ Secondary ☐ Recurrent Infections	
	Mast Cell Disease	*Referring Diagnosis / Comments:*
	Medication Allergy ☐ Antibiotic ☐ Aspirin / NSAID (including AERD) ☐ Chemo ☐ Contrast Dye ☐ DRESS ☐ Drug – Narcotics ☐ Drug - Other ☐ Local Anesthetics ☐ Vaccine Reaction ☐ Perioperative	
	Rhinitis ☐ Allergic Rhinitis ☐ Non-Allergic Rhinitis ☐ Vasomotor ☐ Other:	
	Stinging Insect Allergy • Do you know the date of the reaction? ☐ Yes ☐ No ☐ Unknown Date, if known:	
	Urticaria (Hives) ☐ Autoimmune ☐ Physical ☐ Unknown Cause	*Comments: (such as, what causes the physical hives)*