OAC
OKEMOS ALLERGY CENTER

FAX FORM BACK TO 517.349.5882

APPOINTMENT REQUEST

Date of Request: _____

Patient Information (Please Print):

_____ / _____ / _____ / _____
Last Name | First Name and MI | Date of Birth | MF

_____
Parent/Guardian Name(s) | Preferred contact (x) : Home phone ☐ Work phone ☐ Mobile phone ☐

Insurance: _____

Dr. Lawrence Hennessey ☐ Dr. Manoj Mohan ☐
Andrea Miller NP ☐ No Preference ☐

Referring Physician Information:

_____ / _____ / _____
Ref. Physician's Name (PCP or Subspecialist) | Best time to reach physician | Best contact number

_____ / _____ / _____ / _____
Practice Contact | Name of Practice | Office Phone | Office Fax

Reason for Referral: (Please check the reason for referral and request all supporting documentation)

☐ Allergic Rhinitis
___ Repetitive sneezing
___ Postnasal drip
___ Itchy eyes, ears, nose, throat
___ Wheezing ___Runny nose ___Nasal congestion
___ Sore throat ___Eye tearing

☐ Allergy
___ Food, Specify _____
___ Animals, Specify _____
___ Environment, Specify _____

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

☐ Asthma
___ History of flares related to environmental exposures
___ Frequent use of oral corticosteroids
___ Needs lung function assessment
Has the patient been referred to pulmonary? Yes ☐ No ☐

☐ Atopic Dermatitis
Area of body affected (extremities, trunk, face) _____
Age of onset _____ Frequency of recurrence _____
Degree of Severity _____
Has the patient been referred to dermatology? Yes ☐ No ☐

☐ ___ Dental Patch Testing

☐ Drug Sensitivity/Allergic Reaction
___ Vaccine
___ Antibiotic
___ Local Anesthetic
___ Specified Drug: _____

☐ Eosinophilic Esophagitis
___Endoscopy results, please send results
___ Treatments, Specify _____

☐ Recurrent Infections
___ Sinus ___ Ears ___ Lungs
___ Other _____
Frequency _____
Immune Globulin Levels _____

☐ Stinging Insect Sensitivity
___ Venom (wasp, bee)
___ Type of Insect _____

☐ Urticaria
___ Exercise-induced ___Cholinergic ___Unknown
Has the patient been referred to dermatology? Yes ☐ No ☐

Other Reason: _____

Comments (type of reaction): _____

Diagnostic Tests/Labs/Evaluations: *PLEASE FAX ANY RELEVANT FINDINGS.

PLEASE SEND DEMOGRAPHIC SHEET