

UCSF Health Allergy & Immunology Clinic

NEW PATIENT REFERRAL/CONSULTATION

Thank you for considering a referral to the UCSF Allergy/Immunology Clinic. We are currently experiencing significant access constraints but remain committed to providing care for patients who can benefit from allergy services that are provided at UCSF.

New patients will be seen for a one-time consultation. UCSF Allergy/Immunology Specialty providers will determine the need for ongoing care at UCSF Allergy/Immunology Clinic during the initial consultation. Please select the reason for referral and provide the requested information for the selected referral indication.

For second opinions, we request that the second opinion referral form is completed by the patient's most recent allergist/immunologist.

We cannot schedule an appointment until the requested information is received.

UCSF Allergy/Immunology is currently not accepting referrals for brain fog, chronic fatigue, chemical sensitivity, dizziness, dysautonomia, Ehlers-Danlos, hypertension, MCAS, neuropathic pain, numbness/tingling, POTS, and vertigo. Testing is NOT AVAILABLE for chemical sensitivity, mold toxicity, fragrance, alcohol, coffee, marijuana, and semen. Referrals for these will be returned to the ordering provider.

PATIENT DEMOGRAPHICS

Name of patient: _____

DOB: _____ Interpreter needed: Yes No Language: _____

Home phone: _____ Work or Cell Phone: _____

If child, name of parent: _____

Address: _____

City: _____ Zip: _____

Insurance: Include patient's insurance card (both sides) and HMO authorization if required

PRIMARY CARE PROVIDER INFORMATION

PCP Name: _____ Phone: _____

We kindly request that all patients have a primary care provider who will co-manage patients who need ongoing care at UCSF Allergy/Immunology Clinic.

REFERRING PHYSICIAN INFORMATION

Referring MD: _____ Specialty: _____

Phone: _____ Fax: _____

REASON FOR REFERRAL:

[] ALLERGIC RHINITIS / CONJUNCTIVITIS, CHRONIC RHINOSINUSITIS

History of nasal polyps: Yes No

History of asthma: Yes No

History of atopic dermatitis: Yes No

Allergy treatments tried: _____

Patient interested in allergen immunotherapy (allergy shots or tablets) : Yes No

Allergen immunotherapy injections require weekly to monthly injections for approximately 5 years. If the patient is not able to come to San Francisco in-person with this frequency, we highly recommend that care is established with a local allergist.

Would patient like first visit to be in-person with environmental allergy skin prick testing (tree/grass/weed pollen, mold, animal dander, dust mites, cockroach)? Yes No

If 'Yes' is selected, the first visit will be in-person for environmental allergy skin prick testing. Patient must be able to hold antihistamines for 5 days to do testing. If this is not possible, please select 'No'.

[] ANAPHYLAXIS

What symptoms did patient experience during anaphylaxis? _____

What was the onset and duration of symptoms? _____

What were potential triggers? _____

Recommendations while waiting for first allergy visit:

- Prescribe Epi-pens
- Obtain tryptase level when patient is symptomatic to evaluate likelihood that symptoms are due to allergy

Hives, swelling, repeated vomiting/diarrhea, respiratory distress, low blood pressure, treatment with epinephrine, and/or intubation that occurs within hours after food ingestion is consistent with an allergic reaction.

[] STINGING INSECT ALLERGY

Is the requested testing for yellow jacket, yellow-faced or white-faced hornet, wasp, honeybee?
Yes No

Testing is not available for other non-stinging insects. We will not be able to schedule patients for whom we do not have any available testing or treatment.

[] ASTHMA

History of nasal polyps: Yes No
History of aspirin/NSAID reactions: Yes No
of ED visits for asthma: _____
of hospitalizations for asthma: _____
of intubations for asthma: _____
Asthma treatments tried: _____
Patient interested in allergen immunotherapy (allergy shots or tablets) : Yes No
Patient interested in biologic therapy: Yes No
Patient interested in asthma clinical trials (UCSF is actively enrolling patients with moderate/severe asthma, poor control, and currently on or considering biologics/additional therapy in clinical trials) : Yes No

Would patient like first visit to be in-person with environmental allergy skin prick testing (tree/grass/weed pollen, mold, animal dander, dust mites, cockroach)? Yes No

If 'Yes' is selected, the first visit will be in-person for environmental allergy skin prick testing. Patient must be able to hold antihistamines for 5 days to do testing. If this is not possible, please select 'No'.

[] DRUG / VACCINE ALLERGY

Please select from the list of available testing options:

- Antibiotic – Penicillin
- Antibiotics – Non-Penicillin
- Aspirin / NSAIDs
- Biologics (e.g., rituximab) / Chemotherapy (e.g., platins, taxanes)
- Contrast (iodinated, CT)
- Contrast (gadolinium, MRI)
- General Anesthetics (etomidate, fentanyl, ketamine, midazolam, neostigmine, ondansetron, propofol, sugammadex, succinylcholine, cisatracurium, rocuronium)
- Local Anesthetics
- Progesterone
- Steroids
- Vaccines

If non-penicillin antibiotics, biologics/chemotherapy, general anesthetics, local anesthetics, steroids, or vaccines were selected, please write down specifically which ones the patient needs testing for. **This information needs to be completed before the referral will be processed.**

COVID-19 vaccines: We are able to offer monitored full-dose vaccine administration. However, COVID-19 vaccine skin testing, excipient skin testing, graded dosing, and desensitization is NOT AVAILABLE at UCSF. **We do not write vaccine exemption letters.**

[] EOSINOPHILIA

Please provide results showing peripheral absolute eosinophil counts >1500 on at least 2 separate occasions separated in time by at least one month and/or pathologic confirmation of tissue hypereosinophilia.

History of nasal polyps: Yes No
History of asthma: Yes No
History of travel abroad: Yes No
Biologic treatments tried: _____
Oral steroid use: _____

Would patient like first visit to be in-person with environmental allergy skin prick testing (tree/grass/weed pollen, mold, animal dander, dust mites, cockroach)? Yes No

If 'Yes' is selected, the first visit will be in-person for environmental allergy skin prick testing. Patient must be able to hold antihistamines for 5 days to do testing. If this is not possible, please select 'No'.

[] EOSINOPHILIC ESOPHAGITIS / GASTROINTESTINAL DISEASE

For eosinophilic esophagitis referrals, biopsy results showing >15 eosinophils per high power field in the esophagus must be provided at time of referral.

For eosinophilic gastrointestinal disorder referrals, endoscopy and colonoscopy biopsy results must be provided at time of referral.

Please provide information regarding the treatments (dose, frequency, foods eliminated, duration) tried:

Proton Pump Inhibitors: _____
Swallowed Steroids: _____
Oral Steroids: _____
Elimination Diets: _____
Biologic Treatment: _____

[] FOOD ALLERGY

Food(s) the patient is allergic to: _____

Symptom(s) the patient has with this/these food(s): _____

We currently do not have oral immunotherapy at our office. Please refer to another clinic that would be able to provide this treatment if that is the reason for referral.

Hives, swelling, repeated vomiting/diarrhea, respiratory distress, low blood pressure, treatment with epinephrine, and/or intubation that occurs within hours after food ingestion is consistent with an allergic reaction.

[] IMMUNOLOGY

Please provide the following information.

Infection History (please provide as much information possible such as the infectious organism, dates treated, anti-infectives used for treatment): _____

History of protein losing syndromes: Yes No
History of organ transplant: Yes No
History of B-cell lymphoma: Yes No
History of CLL: Yes No
History of multiple myeloma: Yes No

Immunosuppression History (e.g., B-cell depleting therapy like rituximab or ocrelizumab). Please provide as much information as possible like the reason for treatment, dates of treatment: _____

Lab Results: IgG, IgA, IgM, Tetanus IgG, Pneumococcal IgG levels (all 23 serotypes), Lymphocyte Subsets, Urinalysis

[] MAST CELL

Please provide the following information.

Patient needs venom immunotherapy: Yes No

Labs/Studies: Tryptase Level, C-kit mutation analysis, bone marrow or other tissue biopsy with mast cell counts

[] RASH

Please provide the following information.

Urticaria: Yes No
Angioedema: Yes No
Atopic Dermatitis: Yes No

Please note: If patient is not a candidate for biologic or other specialized allergy therapy, the patient will be referred back to you.

If referral is for atopic dermatitis, would patient like first visit to be in-person with environmental allergy skin prick testing (tree/grass/weed pollen, mold, animal dander, dust mites, cockroach)?
Yes No

If 'Yes' is selected, the first visit will be in-person for environmental allergy skin prick testing. Patient must be able to hold antihistamines for 5 days to do testing. If this is not possible, please select 'No'.