AILergy

REFERRAL FORM (AI Allergy Test)

Patient First Name: _____

Patient Last Name: _____

Sex: M / F

Date of Birth (DD/MM/YYYY): _____

Referred by: Dr._____

Clinic Phone: _____

Report Language: Chinese / English

Collection Date: _____

☐ On Account ☐ Cash Payment

Clinic Chop / Patient Label

PATIENT PROFILE (Please tick one or more)

Data analysis in Anonymous way only (Enjoy $100 discount)

☐ Eczema ☐ AR ☐ Asthma ☐ Urticaria ☐ Food Allergy ☐ Anaphylaxis

☐ Screening ☐ Others: _____

Sample Collection

Phone : 2587-1700 / Fax : 3010-0808

Specimen received by:

Checked by:

Sample Barcode: