**EPUT Children’s Asthma & Allergy Service**

**ALLERGY/ECZEMA Referral Form**

**Please return by email to:** [**epunft.caa@nhs.net**](mailto:epunft.caa@nhs.net)

Telephone: 0344 257 3955

**Referrals that do not meet our criteria or are incomplete will be rejected**

**Allergy Referral Guidance**

1. **Aged 2 to 18 years**
2. **Live within the SSO to SS9 postcode area**
3. **Children and young people should not be referred to the service for non-IgE mediated allergies (e.g. delayed onset >2 hours, symptoms may include eczema, reflux, gastric symptoms etc.)**
4. **For patients under 1 year of age please consider referral to OVIVA for non IgE mediated allergies.**
5. **For allergy care plans for schools and nurseries please contact universal services, i.e. GP, health visitors, school nurses, practice nurse or Allergy UK.**
6. **It is the responsibility of the referring clinician to ensure copies of blood tests/skin prick tests are provided with the referral if available, so the team can provide allergy advice as appropriate**
7. **For further resources and information please see www.allergyuk.org**

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| **SECTION 1 – ALLERGY** *(please tick* ***all*** *that apply)***:** | |
| 1. Suspected immediate reaction (within 2 hours). Symptoms may include: | |
| * Hives |  |
| * Angioedema |  |
| * Anaphylaxis |  |
| * Vomiting |  |
| * Tingling mouth/throat |  |
| * Sudden change in behaviour (irritability) |  |
| 1. The patient has been prescribed an adrenaline auto injector |  |
| 1. Allergies have been confirmed by IgE bloods or skin prick testing |  |

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| **SECTION 2 – ECZEMA** *(please tick* ***all*** *that apply)***:** | |
| 1. Started treatment/creams but are still symptomatic |  |
| 1. Previously required steroid treatments |  |

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| **SECTION 3 – REASON FOR REFERRAL, HISTORY OF SYMPTOMS & CURRENT MEDICATIONS** | | | |
| Give details for referral | | | |
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| History of symptoms | | | |
|  | | | |
| Current Medications | | | |
| Allergy Medications |  | Other Medications |  |

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| **SECTION 4 – PATIENT DETAILS** | | | | | | | | | | | | | | | |
| NHS Number | |  | | | | Surname | | | |  | | | | | |
| First Name |  | | | | Date of Birth | | |  | | | | Gender | |  | |
| Address |  | | | | | | | | | | | Postcode | |  | |
| Parent/Carer Full Name | | |  | | | | | | Parent/Carer Contact No | | | |  | | |
| Carer consent to referral | | |  | Spoken language | | |  | | | | Interpreter required | | | |  |

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| **SECTION 4 - REFERRER’S DETAILS** | | | | | | | |
| Date of referral | |  | | Referee Name |  | | |
| Designation |  | | Service Referring | |  | Contact Number |  |