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

**ALLERGY/ECZEMA Referral Form**

**Please return by email to:** **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**

|  |
| --- |
| **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
 |  |

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

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

|  |
| --- |
| **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 |  |

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