SASKATOON HEALTH REGION

ALLERGY TESTING REQUISITION

Clinical Diagnosis ______________________________

Requesting Physician ____________________________

Additional Copies of Report to: __________________

Collection Date: ______________ Time: __________

Clinic name or billing info: ______________________

____

____

PHN# ____________________ Chart# ___________

Name ______________________________________
Last First

q M q F

Date of birth ______________ Phone _____________
DD/MM/YY

IGE	☐	**Total IGE**
INHAL	☐	**Inhalant Screen** (a mixture including pollens, moulds, danders)
FX5	☐	**Food Screen** (a mixture of eggwhite, milk, cod, peanut, wheat, soy)
ALLER	☐	**Allergens and other Allergy Tests:** list below

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

This requisition must accompany the serum sample and be sent to Room 4900, Royal University Hospital.

Please ensure that all information is complete.

A positive screen will be followed up as appropriate.

Consult with Department of Lab Medicine - Chemistry (655-2164) for specific testing available.

PM Form # 101214 (S) 10/04