Allergy- Immunology Consultation Request

Great Lakes Allergy & Asthma Center, P.C.

To: **Peter M. Ranta, M.D.**

Fax: **(906) 253-0401**

Phone: **(906) 253-0400**

Date/Time of appointment: _____

Date: _____ Time: _____
Called in/ Faxed in

Doctor's Name: _____ Ph.: _____ Fax: _____

Patient's Name: _____ Date of Birth: _____

Patient's Phone (Home): _____ (Work): _____

Address: _____

Insurance Name: _____

Contract #: _____ Group #: _____ Plan #: _____

Reason for request: (check all that apply)

- ○ Allergies
- ○ Angioedema
- ○ Asthma
- ○ Bee sting allergy
- ○ Conjunctivitis
- ○ Drug allergy/ reaction
- ○ Ear symptoms
- ○ Eczema
- ○ Epistaxis
- ○ Food allergy
- ○ Frequent infections
- ○ Hives
- ○ Insect sting allergy
- ○ Nasal congestion
- ○ Pruritus
- ○ Rash
- ○ Rhinorrhea
- ○ Shortness of breath
- ○ Sinusitis
- ○ Wheezing

- ○ Other: _____

_____

Please evaluate and treat as needed.

_____ _____
Physician Signature Date