Starship
Child Health

# Referral for Food or Drug Challenge

**MUST ATTACH PATIENT LABEL HERE**

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

**Please ensure you attach the correct visit patient label**

Parent names: _____ Parent mobiles: _____

Short notice possible? Yes ☐ No ☐ _____

Drug/Food to be challenged _____

Per protocol Yes ☐ No ☐ Special food / non protocol Yes ☐ No ☐

**History:** Sensitised but never exposed? Yes ☐ No ☐ *(If Y go to investigations)*

Initial reaction
- Age _____
- Amount ingested _____
- Symptoms _____
- Treatment _____

Interval exposures
1) Age _____
   - Symptoms _____
   - Treatments _____
2) Age _____
   - Symptoms _____
   - Treatments _____
3) Other? *Please detail on reverse*

**Investigations:**

| | Date: | Date: | Date: |
|---|---|---|---|
| SPT | | | |
| ssIgE | | | |

**Other:** Asthma If Yes medications: _____

Other: _____

Skin tests on day? _____

Referred by _____ Date _____

_____
*Sign*

***(Sections below for Immunology Service Use thanks)***

Graded doses: _____

Timing interval: _____

Reviewed at Immunology team meeting: _____/_____/_____ Accepted for challenge: Yes ☐ No ☐

Challenge time frame: urgent routine future ( ~ date: _____ ) Triage 1 2 3

REFERRAL FOR FOOD OR DRUG CHALLENGE

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