



Patient Referral
to Latitude Food Allergy Care
Fax to 310-606-1024

Referring Provider: _____

Referring Provider Phone/Email: _____

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Phone Number: _____

Parent/Guardian Email: _____

Diagnosis:

Referred for:

- | | |
|---|--|
| ☐ Food Allergy Consultation | ☐ Oral Immunotherapy |
| ☐ Food Allergy Diagnosis | ☐ Xolair |
| ☐ Food Challenges | ☐ Long-Term Food Allergy Care |
| ☐ Early Introduction for Infants | |

Notes:

Preferred Clinic: ☐ West LA ☐ Sherman Oaks ☐ Irvine ☐ San Diego North County

Clinics 100% focused on the testing, treatment, and care of food allergies.

Member of Children's Hospital of Los Angeles Care Network

Multiple Southern California Locations • (888) 528-1592 • Fax (310) 606-1024

hello@latitodefac.com • www.latitudefoodallergycare.com