The Hong Kong Society for Paediatric Immunology Allergy and Infectious Diseases –
Paediatric Covid-19 Vaccine Allergy Safety Assessment

Referral letter

Referral Doctor	Referred Patient
Doctor's name:_____	Patient's name:_____
Clinic phone number: _____	Contact phone number (1): _____
Clinic fax number: _____	Contact phone number (2): _____

Referral reason:

☐ History of ***immediate*** and #***severe*** allergic reactions to **^drugs or vaccines containing polyethylene glycol (PEG)**

Specify culprit drug(s): _____

Specify time from drug intake to onset of symptoms: _____hours

Specify organ involvement (circle as appropriate):

Skin / Respiratory / Cardiovascular / Severe gastrointestinal

☐ History of ***immediate*** allergic reaction to the **1st dose of BioNTech vaccine**

Specify time from vaccination to onset of symptoms: _____hours

Specify organ involvement (circle as appropriate):

Skin / Respiratory / Cardiovascular / Severe gastrointestinal

Specify date of receiving the **1st dose of BioNTech vaccine**: _____

* "immediate" means within 4 hours;
# "Severe" refers to occurrence of any non-cutaneous adverse reactions (e.g. respiratory, cardiovascular or severe gastrointestinal);
^ referred to Hong Kong College of Paediatricians website at http://www.paediatrician.org.hk/ for the most updated version (see QR code).

(To be filled by Allergy Clinic Staff)

Plan:

☐ Fit for vaccination at a designated vaccination venue according to the approved age eligibility (see separate Reply Letter)

- ☐ A routine but not expedited Allergy clinic appointment will arranged to provide clinical care for their allergic condition unrelated to the COVID vaccine
- ☐ Allergy clinic appointment will not be arranged

Referral doctor please kindly advise subject and guardian the above plan

☐ Require further COVID vaccine allergy evaluation with an expedited Allergy clinic appointment

Appointment at an Allergy clinic

Date/ time of allergy clinic appt: _____

Clinic name and location: _____

Subject and guardian will be contacted by an Allergy clinic staff after receiving the referral

Name of Doctor: _____ Signature: _____ Date: _____

Referral Centres Contact Information:

Public Service:

Prince of Wales Hospital Paediatric Specialist Out-patient Clinic:	3505 4440 (phone)	3505 4633 (fax)
Queen Elizabeth Hospital Paediatric Specialist Out-patient Clinic:	3506 6226 (phone)	3506 6140 (fax)
Queen Mary Hospital Paediatric & Adolescent Medicine Specialist Out-patient Clinic:	2255 3237 (phone)	2819 3655 (fax)
Yan Chai Hospital Paediatrics and Adolescent Ambulatory Centre:	2417 5817 (phone)	2149 6039 (fax)

List. of Specialist in Paediatric Immunology Allergy and Infectious Diseases:
https://www.mchk.org.hk/english/list_register/list.php?type=S&fromlist=Y&advancedsearch=Y®no=S56
or
https://www.mchk.org.hk > List of Registered Medical Practitioners > Specialist Registration > 54 Paediatric Immunology, Allergy and Infectious Diseases S56