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**Perioperative Allergy Network**

Please complete this form if you would like to become a network member of the Perioperative Allergy Network

Title:

Name:

Email:

1. **What is your primary specialty?**

**Allergist Immunologist Anaesthetist Dual-trained**

1. **At which hospital or trust do you work? \***

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 **\*If working for a Trust, how many sites does the Trust have?**

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1. **If you are an allergist, immunologist, or anaesthetist working in the anaesthetic allergy clinic, which Trusts refer their patients to you for investigation of anaesthetic allergy?**

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1. **If you are an anaesthetist NOT working in the anaesthetic allergy clinic, which Trust do you refer your suspected anaesthetic allergy patients to for further investigation?**

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1. **Who do you treat in your clinic?**

|  |  |  |
| --- | --- | --- |
| **Adults** | **Children** | **Both** |

 Please send completed form to **info@bsaci.org**.