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Cardio 1

RESPIROLOGY REFERRAL

Provider Name: _____
Family Physician: Yes? ☐ No? ☐
Clinic / Hospital: _____
Address: _____
_____
Phone: _____
Fax: _____
Date: _____

PATIENT INFORMATION

Name: _____
PHN: _____ MHSC# _____ ☐ Male
DOB: (dd/mmm/yy) _____ ☐ Female
Address: _____ ☐ Other _____
City: _____ Province: _____
Postal code: _____ Email: _____
Home phone # _____
Cell: _____
Work: _____
Other Patient Details: _____

☐ Outpatient ☐ Inpatient – site: _____

REFER TO: ☐ Specific Respirology Specialist: _____ ∗OR∗ ☐ Earliest Available

1) Appointment

☐ **Urgent** (Typically Within 1 to 2 weeks) **Please Call us if Appt is required sooner**

☐ **Semi-Urgent** (Typically Within 2 to 4 weeks)

☐ **Elective** (An attempt will be made to be seen within 4 - 8 weeks)

2) REASON FOR REFERRAL (Check all that apply)

☐ COPD
☐ Smoking Cessation Consult
☐ Inhaler Technique Consult

Abnormal Pulmonary Function Testing Consult
Other: _____

3a) AVAILABLE TESTING

☐ Spirometry (on site)
☐ 6 Minute Walk Test (MWT) (on site)

3b) Indication: _____

All Testing will be subject to review and performed in consultation with one of our physicians

($): Fees may apply for uninsured services related to these tests

Please include recent relevant medical history, medication records, investigations, recent spirometry, pulmonary function tests, sputum samples, blood gases and imaging and lab results.

This referral will be triaged by respirology staff. For prompt booking, please ensure all sections are fully completed.

Signature: Date:

Cardio 1
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