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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
**Semi-Urgent
**Elective

Diagnostic test may be performed at the Respirologist discretion

2) REASON FOR REFERRAL

☐ **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
2-230 Osborne Street, Winnipeg, MB, R3L1Z5
Ph: 204-287-5222 Fax: 204-287-5223