

THE ASTHMA AND RESPIRATORY HEALTH CENTRE

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PATIENT NAME: _____ Date: _____

Address: _____

Telephone: _____ Alternate phone: _____

OHIP: _____ VC _____ Date of Birth: _____

Reason for referral (please circle):

COPD Asthma Hemoptysis Lung mass Pulmonary Hypertension Dyspnea NYD

Cough NYD Occupational lung disease Thromboembolic disease Bronchiectasis Pleural Disease

Interstitial lung disease Neuromuscular Disease

Other (specify): _____

Patient History: _____

Investigations: Where/ when was the test performed?

Chest x-ray YES NO _____

CT Scan YES NO _____

Pulmonary Function Test YES NO _____

Lab work YES NO _____

Please send results of investigations with the referral form and imaging on CD (if available) WITH the patient.

Current Treatment: _____

We will contact your office with the appointment.

REFERRING PHYSICIAN

Name (print): _____ CPSO#: _____ Billing #: _____

Signature: _____ Telephone: _____

Fax: _____ Email if e-records are preferred: _____

Family doctor if different from RP: _____