THE ASTHMA AND RESPIRATORY HEALTH CENTRE

Medical Director: Dr Raymond Gottschalk
Respirologist: Dr Marina Lerner

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PATIENT NAME:_____ Date: _____

Address:_____

_____

Telephone:____ _____ Alternate phone: _____

OHIP:_____VC_____ Date of Birth:_____

Reason for referral (please circle):

Ĭ COPD Ĭ Asthma Ĭ Hemoptysis Ĭ Lung mass Ĭ Pulmonary Hypertension Ĭ Dyspnea NYD

Ĭ Cough NYD Ĭ Occupational lung disease Ĭ Thromboembolic disease Ĭ Bronchiectasis Ĭ Pleural Disease

Ĭ Interstitial lung disease Ĭ Neuromuscular Disease

Other (specify):_____

Patient History: _____

_____

Investigations: Where/ when was the test performed?

Chest x-ray Ĭ YES Ĭ NO _____

CT Scan Ĭ YES Ĭ NO _____

Pulmonary Function Test Ĭ YES Ĭ NO _____

Lab work Ĭ YES Ĭ 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: _____