



**REFERRAL
PULMONARY REHAB**



Physician referral/signature required.

First Name: _____ Address: _____
 Last Name: _____
 Gender: Male Female City: _____
 Date of Birth: _____ Province: _____
 Patient ID: _____ Postal Code: _____
 H.I.N.: _____ Phone: _____
 Version Code: _____ E-Mail: _____
 Family Doctor: _____ Respirologist/Internist: _____

Referring Clinician	<input type="checkbox"/> Respirologist	<input type="checkbox"/> General Internist	<input type="checkbox"/> Primary Care Physician
	<input type="checkbox"/> Other (specify) _____		
Point of Referral	<input type="checkbox"/> Emergency	<input type="checkbox"/> Inpatient Unit	<input type="checkbox"/> Physicians Office
	<input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Other (specify) _____		
Referral Event	<input type="checkbox"/> Moderate COPD	<input type="checkbox"/> Severe COPD	<input type="checkbox"/> Pulmonary Fibrosis
	<input type="checkbox"/> Other (specify) _____		

Referral Event Date: _____ (MM/DD/YYYY) Hospitalization Required: Yes No Unknown

Please fax the MOST RECENT PFT and all pertinent consultations or diagnostic tests along with the completed referral form.

CENTRALIZED REFERRAL – FAX TO: 519-257-5144

 Referring Physician (Print Clearly) Referring Physician Signature Date (MM/DD/YYYY)

For inquiries, please call the Respiratory Therapy Department at 519-257-5111 Ext. 76701

