



CLINIC REFERRAL FORM

Date:
 Ref MD:
 MSP #:
 Address:
 Phone:
 Fax:
 Email:
 Signature:

Patient Name:
 PHN:
 DOB:
 Sex at birth: M / F
 Address:
 Cell:
 Home:
 Work:
 Email:

Reason for Referral:

HPI:

Timeframe:

- Routine <6 mos
- Semi-Urgent <6-8 weeks
- Urgent < 2 weeks

Spirometry requested:

- Yes (please fill separate spiro req)
- No

Family doctor / other CC info:

Respiratory History:

Past Medical History:

Social History:

Medications:

Allergies:

Other:

- Needs interpreter language _____

Please fax this form along with your detailed notes/records.

OFFICE USE ONLY
 Appointment Date: _____ Appointment Time: _____