Specialist and Walk in Clinic

Rapid Access to ASTHMA/COPD Clinic Requisition

PLEASE FAX COMPLETED REQUISITIONS TO 905-296-6344

905-979-2352 | 574 Upper James Street, Hamilton Ontario

PATIENT INFORMATION

Surname: .....
First Name: .....
Address: .....

DOB (YYYY/MM/DD): .....
Gender: ☐ Male ☐ Female ☐ Other
Health Card #: ..... **VC:** .....

Phone (Home): ..... | **Phone (Mobile):** ..... | **Email:** .....

REFERRAL DETAILS & TRIAGE

Requested Priority:
☐ Routine ☐ Urgent

Service(s) Requested:
☐ Respiratory Testing ☐ Respirology Consultation

CONCERN(S) / INDICATION(S) TRIGGERING REFERRAL

☐ Asthma ☐ Dyspnea NYD ☐ Cough NYD ☐ Interstitial Lung Disease
☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Occupational Exposure

Other: .....

Brief Description of Referral, History, Management, and Investigations:

CUMULATIVE PATIENT PROFILE

☐ **CPP attached separately** (If checked, you may leave the fields below blank)

Current Problem List:	**Current Medications:**
Past Medical History:	**Allergies:**

Supporting Documentation:
Please attach all relevant laboratory and diagnostic investigations with this requisition.

REFERRING PHYSICIAN INFORMATION

Physician Name: .....
Address: .....

Physician Signature: _____

Phone: .....
Fax: .....
Billing #: .....
Date: .....