

**INSTRUCTIONS FOR REFERRAL**

1. Please ensure the below referral form is completed, patient information provided to patient, and any supporting documentation attached.
2. Please fax referral to Respiratory Therapy Services at 613-345-8342

**NOTE: Incomplete referrals will be returned by fax and not processed until complete.**

Date of Referral (DD/MM/YYYY): \_\_\_\_\_

Referring Provider Information	
Referring Provider Name (please print): _____	
Referring Provider Contact Number: _____	
Referring Provider Fax Number: _____	
Patient Demographics	
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> N (N= Gender Neutral or choose not to disclose)	
Last Name: _____	First Name: _____
Health Card #/VC: _____	Date of Birth: (DD/MM/YYYY): _____
Contact Number: _____	Address: _____
City: _____	Postal Code: _____
Medical Information	
Precautions: <input type="checkbox"/> MRSA <input type="checkbox"/> C-Diff   Other: _____	
Allergies: _____	
Code Status: <input type="checkbox"/> Full Code <input type="checkbox"/> DNR (DNR forms must be attached)	
Priority	
<input type="checkbox"/> Urgent (within 3 weeks) Reason _____ <input type="checkbox"/> within 2 months <input type="checkbox"/> Routine	
Indication for Testing	
<input type="checkbox"/> COPD <input type="checkbox"/> Cough <input type="checkbox"/> Pre-op (Surgery Date if known: _____)	
<input type="checkbox"/> Asthma <input type="checkbox"/> ILD <input type="checkbox"/> Transplant	
<input type="checkbox"/> Dyspnea <input type="checkbox"/> Follow-up <input type="checkbox"/> Other _____	
Pulmonary Function Testing	
<input type="checkbox"/> Spirometry pre bronchodilator <input type="checkbox"/> Spirometry post bronchodilator (200-400 mcg salbutamol) <input type="checkbox"/> Lung Volumes <input type="checkbox"/> Diffusing capacity <input type="checkbox"/> All of the above	<input type="checkbox"/> Methacholine Challenge study for diagnosing asthma when spirometry is not definitive. Spirometry with bronchodilator must have been completed within 3 months of challenge study
<b>PLEASE NOTE: Patients having PFT for diagnostic assessments will be instructed to stop taking inhaled therapy for 24 -48 hours prior to testing.</b>	
Special Procedures	
<input type="checkbox"/> Arterial blood gas <input type="checkbox"/> Room air <input type="checkbox"/> with oxygen _____ LPM <input type="checkbox"/> Home oxygen assessment for MOH funding <input type="checkbox"/> Pulse oximetry at rest <input type="checkbox"/> with exertion <input type="checkbox"/> Six minute walk test <input type="checkbox"/> IEA independent exercise assessment for home oxygen funding. Single blind air\oxygen exertional oximetry <input type="checkbox"/> MIP\MEP indicated for suspected respiratory muscle weakness	
Ordering Practitioner Signature: _____	
<b>If requiring hard copy of results please identify by placing fax number here:</b>	