76 Grenville Street, 4th Floor, Toronto, ON M5S 1B2
Tel: 416-323-6137 Fax: 416-323-6132

PATIENT IDENTIFICATION

RESPIROLOGY REFERRAL

Date: ______/___/___
YYYY/MM/DD

❑ **URGENT** or ❑ First available ❑ Or ____

Ability to communicate in English. ❑ Yes ❑ No

❑ Translation services required for ____________________ language

REASON FOR REFERRAL

❑ **RESPIRATORY SYMPTOMS**

Shortness of breath	❑ Yes	❑ No	If Yes, how long? ______
Cough	❑ Yes	❑ No	If Yes, how long? ______
Wheeze	❑ Yes	❑ No	If Yes, how long? ______
Radiology CXR/CAT scan	❑ Yes	❑ No	If not done at WCH, please attach
Positive Mantoux test	❑ Yes	❑ No	Longstanding or recent report? _________________
Smoking Hx ❑ Never	❑ Current	❑ Past, years smoking ______, years quit ______	

❑ **ASTHMA/COPD**
Spirometry or Pulmonary Function tests ❑ Yes ❑ No Abnormal CXR ❑ Yes ❑ No

(please attach all supporting documentation/results)

❑ **SLEEP MEDICINE**

❑ Concerns of Obstructive sleep apnea
❑ Disruptive snoring or witnessed apneas
❑ Restless leg symptoms
❑ Increased day time somnolence
❑ Insomnia
❑ Previous sleep study

❑ Other ____

CLINIC USE ONLY: Appointment information: PLEASE NOTIFY YOUR PATIENT

Date: ______________________________Time:__________________, Physician: ______________________

REFERRING PHYSICIAN

Name: ____ Billing Number: _________________________________

Tel: ____ Fax: ____

Address: ____

Referring Physician Name: ___________________________ Signature: _____________________________________

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