WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
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Toronto, Ontario
M5S 1B2

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RESPIROLOGY REFERRAL FORM

URGENCY: ❑ Routine ❑ Semi-Urgent ❑ Urgent

REFERRAL DATE: ____/____/______
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:__________ HCN:____________________

Name:________________________________

Sex:__________ Date of Birth:______/____/______
DD / MM / YYYY

Address:________________________________

Telephone:______________________________

ADDITIONAL PATIENT INFORMATION

Preferred name: WCH Medical Record Number (*if known*):

Gender: Pronouns: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other: __________

Other insurance coverage (IFH, UHIP, etc.): ❑ Self-pay

Language spoken: Interpreter required: ❑ Yes ❑ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: ____________________

Signature: ____________________

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ______________________________
Primary Care Provider Telephone: ______________________________

REASON FOR REFERRAL

☐ Respirology Symptoms: ○ *shortness of breath* ○ *cough* ○ *wheeze*

☐ Abnormal Radiology:______________________________

☐ Asthma/COPD:______________________________

☐ Interstitial Lung Disease: ______________________________

☐ Sleep: ○ *assessment for sleep apnea* ○ *assessment for sleep disorder*

☐ Other: ______________________________

INVESTIGATIONS (in last year)

Radiology:
☐ ordered
☐ performed (please attach)

Pulmonary Function Studies:
☐ ordered
☐ performed (please attach)

Sleep Studies:
☐ ordered
☐ performed (please attach)

Other: ____________________

MEDICATIONS

SMOKING HISTORY

☐ never smoked
☐ current smoker
☐ past smoker
☐ other: ____________________

ADDITIONAL INFORMATION

Please attach:
☐ current conditions
☐ past medical history
☐ family history

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