**Adult COPD and Asthma Clinic Referral**

**Medicine Treatment Clinic**

Phone: 705-728-9090 Ext: 23300  
Fax: 705-728-3039

Please indicate urgency:  
- [ ] 4 Weeks  
- [ ] 2 Weeks  
- [ ] First Available

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<th>Adult COPD Clinic</th>
<th>Adult Asthma Clinic</th>
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| • Home O2 Assessment (including ABG if required)  
• Ambulatory: Yes ____ No ____  
• Pre & Post Bronchodilator Spirometry  
• Consult with COPD Educator and Respirologist | • All appointments include oximetry and spirometry  
• Consult with Asthma Educator and Physician |

**Past Medical History:**

**Current Medications:**

**Diagnosis/Goal(s) of Treatment:**

**Relevant Lab/Diagnostic Tests Pending or Results:** *Please attach with referral or fax to 705-728-3039*

Signature of Referring Physician ____________________________ Date __________________

Referring Physician Name Print ____________________________ Physician Billing Number _____________

Physician Office Phone ____________________________ Physician Office Fax ____________________________

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For Office Use

Triage By: ____________________________ Triage Date: ____________________________

Action Plan: ________________________________________________________________