Royal Victoria Regional Health Centre

PATIENT NAME: _____

DOB: _____

HRN: _____

HC#: _____

PHONE: _____

# 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

☐ **Adult COPD Clinic**
- Home O2 Assessment (including ABG if required)
- Ambulatory: Yes ____No____
- Pre & Post Bronchodilator Spirometry
- Consult with COPD Educator and Respirologist

☐ **Adult Asthma Clinic**
- 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 _____

For Office Use

Triage By: _____ Triage Date: _____

Action Plan:

_____



201 Georgian Drive | Barrie ON | L4M 6M2 | 705.728.9802
www.rvh.on.ca

R.CDMCR

Inspiring care...