Kingston Community Health Centres
Centres de santé communautaire de Kingston

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# REGIONAL LUNG HEALTH PROGRAM

# CENTRAL REFERRAL FORM

## PATIENT DEMOGRAPHICS

**Last Name:** _____ **First Name:** _____

**Health Card #:** _____ **Gender:** _____

**Date of Birth:** _____

**Address:** _____

**Phone Number:** _____ **Language Preferred:** _____

**Primary Care Provider Name: (please state if patient does not have one):** _____

## SERVICES REQUESTED

**URGENT Referral:** ***Recent COPD Exacerbation, ER Visit or Discharge from Hospital*** ☐

☐ **COPD Education & Self Management**

☐ **STOP Program services, including NRT**

☐ **Spirometry, including bronchodilator**

☐ **Respiratory Rehabilitation (may include onsite consultation with General Internist)**

## CLINICAL DETAILS & SUPPORTING DOCUMENTS **(if relevant)**

**Reason for referral:** _____

_____

_____

☐ **Cumulative Pt. Profile**

☐ **Consultant Reports**

☐ **ER/Discharge Summary (if recent)**

☐ **Pulmonary Function Testing or Spirometry**

☐ **Chest Xray**

☐ **Electrocardiogram/ Echocardiogram/Stress Test**

**Is the patient currently on oxygen?** ☐ Yes ☐ No

**If yes, please provide oxygen titration parameters:** _____

**Titrate oxygen to 88-92%** ☐

## REFERRING PROVIDER

**Referring MD/NP:** _____ **Billing #:** _____

**Phone:** _____ **Fax:** _____ **Date:** _____