PEDIATRIC RESPIROLOGY & ALLERGY SERVICE

Please fax completed form to **(905) 521-2654**. Contact booking desk (905) 521-2100 x78517 with any further inquiries

□ Consult Only □ Consult and Follow-Up

Patient Information

Patient Name: _____

DOB: _____ __Male __Female

Health Card # _____(OHIP)

Address: _____

_____ Postal Code: _____

Telephone:

Family Physician _____

Referring Physician Information

Name:_____
Address:

Postal Code:

Telephone:

Fax:

E-mail (Optional):
Physician Billing #: _____
Date of Referral: _____

REASON(S) FOR REFERRAL *(Please select all that apply)*

□ Asthma
□ Allergic Rhinitis
□ Chronic Cough
□ Chest Pain
□ Eczema
□ Exercise Intolerance
□ Environmental / Seasonal Allergy
□ Food Allergy
□ Recent Anaphylaxis
□ Recurrent pneumonia
□ Urticaria
□ Other:
_____
_____

Details of Referral:

_____
_____
_____
_____
_____
_____

Medications:
1.
2.
3.
4.
5.
6.
7.
8.

Additional Information (please complete for appropriate triaging)

Other medical conditions:_____
_____
_____
_____
Primary Language: _____
Interpreter Required? □ Yes □ No

For Asthma:
In the past 12 months:
□ Oral Corticosteroid courses: _____
□ Number of ED visits: _____
□ Number of Hospitalizations: _____

Relevant Investigations or Documents (Please Attach)

□ Diagnostic Imaging □ Pulmonary Function Test □ Allergy Testing □ Other _____