SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Adult Asthma Program

Health Record #: _____ Complete or place patient label here

Patient Name: *(Print first, last)* _____

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

Adult Asthma Program Referral

Please fax to 905-853-2211

Patient Name: *(print first, last)*

Patient Address:

Patient Phone Number: | **Patient Alternate Phone Number:**

Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

Primary Care Physician Contact Number:

CURRENT MEDICATIONS (including dosages):

_____ _____

_____ _____

_____ _____

_____ _____

PERTINENT PATIENT HISTORY:

_____

_____

_____

_____

OTHER INSTRUCTIONS TO ASTHMA EDUCATOR:

_____

_____

Signage of this form will cover all educational sessions, pulmonary function testing, and educational materials as necessary.

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: *(print first, last)* | **Billing #:**

Referring Physician Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**

CLINIC USE ONLY

Date referral received: mm / dd / yy | **APPOINTMENT – Date:** dd / mm / yy **Time:** _____

S-PHYRAA