Alberta Health Services

## Calgary COPD & Asthma Program
## Respiratory Education Referral

**Administration Office Only**
**4500 – 16th Avenue NW**
**Phone: 403-944-8742**

**Patient Name** _____
**Address** _____
_____
**City** _____ **Postal Code** _____
**DOB** _____ **PHN** _____
**Daytime Phone** _____
**Family Dr. Name** _____
**Family Dr. Office Phone** _____
**Family Dr. Office Fax** _____

***Note:** This is a referral for **respiratory education** by a Certified Respiratory Educator. Patient will not be reviewed by a Respirologist. Respiratory assessment typically includes spirometry for diagnosis/management (unless contraindicated). If you **DO NOT** want your patient to have spirometry, please explain below:

_____

**Reason(s) for Referral:** *(Patient must be 16 years and older)*

☐ Asthma ☐ COPD and/or ☐ Tobacco Reduction

**Referral Information** *(*attach if available)*

☐ Pulmonary Function Test *(asthma and COPD patients)*
☐ Chest x-ray *(COPD patients only)* – valid within the past year

**Requested Action(s):**

☐ Confirm and/or advise diagnosis
☐ Suggest management
☐ Review and teach inhaler technique
☐ Design and teach action plan related to asthma or COPD

***List/attach information that may affect consultation/care:***

☐ Language Barrier _____
☐ Physical limitation(s) _____
☐ Social/Psychological _____
☐ Economic _____

**Respiratory Medications** _____

_____

**Relevant Medical History** _____

_____

_____

**Other** _____

**Referred by: **Please PRINT name of physician/nurse practitioner**

Physician/Nurse Practitioner _____ PRAC ID # _____

**Physician's Signature** _____ **Date** *(yyyy-Mon-dd)* _____

## Please fax completed form to: 403-283-3406