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