NORTH BAY
BREATHING CLINIC

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TEL **705-478-6888**

FAX **705-478-8711**

RESPIROLOGY REFERRAL FORM

Please complete all sections and include relevant investigations.

1 PATIENT INFORMATION

FULL NAME

DATE OF BIRTH YYYY MM DD

HEALTH CARD NUMBER

PHONE

ADDRESS

2 REASON FOR REFERRAL

PRIORITY ☐ **Non-urgent** ☐ **Urgent**

CLINICAL QUESTION AND RELEVANT HISTORY

ATTACH PFTs, chest X-ray or CT chest, echocardiograms and relevant blood work.

3 REFERRING PHYSICIAN

NAME

OHIP BILLING NUMBER

SIGNATURE

DATE YYYY MM DD

FAX COMPLETED REFERRALS TO 705-478-8711