



Airway Clinic Referral Form ASTHMA / COPD / Diagnostics

St. Mary's General Hospital
911 Queen's Blvd.
Kitchener, ON, Canada
N2M 1B2
Tel: 519.744.3311

Patient Name: _____ HCN#: _____

Date of Birth: _____ Gender: Male Female

Parent Name (if applicable): _____

Address: _____

Phone (Home): _____ (Work): _____

Physician/Nurse Practitioner: _____

Reason for Referral: _____

Diagnostics

- Pulmonary Function Testing** (must be \geq 12 years of age)
includes spirometry, lung volumes, diffusion capacity, oxygen saturation
- Pulmonary Function Testing with Arterial Blood Gases**
Please indicate: Room Air On Oxygen _____ liters per minute
- Spirometry Testing** includes oxygen saturation
- Arterial Blood Gases** **Oxygen Saturation**
Please indicate: Room Air On Oxygen _____ liters per minute
- Cardio-Pulmonary Exercise Testing (C-PET)** to be ordered by Respiriologists only
- 6 Minute Walk Test** to be ordered by Respiriologists only
- Individual Exercise Assessment for Home Oxygen** to be ordered by Respiriologists only

Education

- Asthma Clinic** (includes spirometry, self-management education)
- COPD Activation** (5 session education and exercise program, assessment done at SMGH, exercise classes done at SMGH Cardiac Rehab site in Waterloo)
- COPD Education Only** (only for those not appropriate for exercise program)
Please indicate reason for no exercise: _____
- Smoking Cessation Counseling** (individual counseling, baseline spirometry for those at risk for COPD)
- Adult Cystic Fibrosis Clinic** (includes spirometry, self-management education)

Signature of Referring Physician: _____ Date: _____

PLEASE FAX REFERRAL FORM TO 519-749-6816

Please call the Airway Clinic at 519-749-6868 (option 1)
if you have any questions or concerns or visit our website: www.smgh.ca

SMGH Airway Clinic Response:	Please notify your patient an appointment has been scheduled for:
Date: _____	Time: _____