AIRWAY CLINIC REFERRAL FORM
ASTHMA / COPD / DIAGNOSTICS

Patient Name: ________________ Parent Name (if applicable): ______________________

Date of Birth: ________________ Gender: _____ HCN#: ______________________

Phone (Home): ________________ (Work): ______________________________________

Physician/Nurse Practitioner: ____

COMMENTS: ____

DIAGNOSTICS

□ **Pulmonary Function Testing** (includes spirometry, lung volumes, diffusing capacity)

□ **Spirometry Testing** □ **Oxygen Saturation**

Arterial Blood Gases □ Room Air □ On Oxygen _____ litres per minute

□ **Cardio-Pulmonary Exercise Testing (C-PET)** *to be ordered by Respirology only*

□ **6 Minute Walk Test** *to be ordered by Respirology only*

□ **Air/Oxygen Exercise Challenge Test** *to be ordered by Respirology 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**