

Please fax completed form to **(905) 521-2654**. Contact booking desk **(905) 521-2100 x78517** with any further inquiries

Consult Only Consult and Follow-Up

Patient Information

Patient Name: _____
 DOB: _____ __ Male __ Female
 Health Card # _____ (OHIP)
 Address: _____
 _____ Postal Code: _____
 Telephone: _____
 Family Physician _____

Referring Physician Information

Name: _____
 Address: _____
 Postal Code: _____
 Telephone: _____
 Fax: _____
 E-mail (Optional): _____
 Physician Billing #: _____
 Date of Referral: _____

REASON(S) FOR REFERRAL *(Please select all that apply)*

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Exercise Intolerance | <input type="checkbox"/> Recent Anaphylaxis | _____ |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Environmental / Seasonal Allergy | <input type="checkbox"/> Recurrent pneumonia | _____ |
| <input type="checkbox"/> Chest Pain | | <input type="checkbox"/> Urticaria | |

Details of Referral:

Medications: 1. _____ 5. _____
 2. _____ 6. _____
 3. _____ 7. _____
 4. _____ 8. _____

Additional Information (please complete for appropriate triaging)

Other medical conditions: _____ **For Asthma:**
 _____ *In the past 12 months:*
 _____ Oral Corticosteroid courses: _____
 _____ Number of ED visits: _____
Primary Language: _____ Number of Hospitalizations: _____
Interpreter Required? Yes No

Relevant Investigations or Documents (Please Attach)

- Diagnostic Imaging Pulmonary Function Test Allergy Testing Other _____