North Bay Pulmonary Centre

RAPID ACCESS RESPIRATORY CLINIC REFERRAL FORM

Referral Criteria:

- Asthma with recent exacerbation
- COPD with recent exacerbation
- Pulmonary Rehab for COPD

PLEASE FAX TO 705-479-5100

Date of Referral:

Patient Information		
Last Name:	**First Name:**	**Date of birth:**
Address:	**City:** **Postal Code:**	**HCN:**
Home Phone:	**Cell phone:**	**E-mail:**
Referring Health Care Provider		
Name:	**OHIP billing number:**	**Fax Number:**

Reason for Referral

☐ **Asthma with exacerbation within the past 12 months** **Date of last exacerbation (MM/YY)** _____

☐ **COPD with exacerbation within the past 12 months** **Date of last exacerbation (MM/YY)** _____

☐ **Assessment for Pulmonary Rehab (for COPD only)**

North Bay Pulmonary Centre

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