



## 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

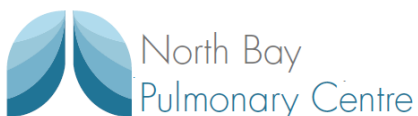
Name:

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)



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