Soldiers' MEMORIAL HOSPITAL Orillia

REGIONAL PAEDIATRIC ASTHMA CLINIC
REFERRAL FORM
Fax: (705) 330-3229 Telephone: (705) 325-2201 EXT.3182

PATIENT INFORMATION

Name: _____ DOB: _____ (YY/MM/DD)

HC#: _____ Version: _____ MRN:_____

Address: _____ City: _____ Postal: _____

Telephone #: _____ Other #: _____

REFERRAL INFORMATION

Education-only option is now available-Please indicate below:

☐ Education-only session with the certified asthma educator (with spirometry, if applicable)

☐ Consultation with the asthma paediatrician, including spirometry and education

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Current Medications:

☐ QVAR 100mg

☐ Alvesco 100mcg / 200mcg *(please circle)*

☐ Advair 125mcg / 250mcg *(please circle)*

☐ Flovent 125mcg / 250mcg *(please circle)*

☐ Singulair ____mg

☐ Other:_____

Emergency Department visits in the past year? **YES / NO** *(please circle)* Date(s):_____

Oral Steroids in past year? **YES / NO** *(please circle)*

Previous admissions for asthma? **YES / NO** *(please circle)* Date(s):_____

Previous intubation: **YES / NO** *(please circle)*

Please indicate if previous Paediatrician involved: _____

Signature:_____ **CPSO:**_____ **Date:**_____

OFFICE USE ONLY:

Paediatrician: _____ Date: _____