Regional Paediatric Asthma Clinic

Referral Form

NAME _____ DOB: _____ (dd/mmm/yyyy)

ADDRESS _____ MOH: _____

_____ Telephone #: _____

_____ Alternate #: _____

Family Physician _____ Referring Physician (if different) _____

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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Age:_____

Current medications:

☐ QVAR 100mcg

☐ Alvesco 100 mcg, 200mcg (circle)

☐ Advair 125mcg, 250mcg (circle)

☐ Flovent 125 mcg, 250mcg (circle)

☐ Singulair ___ mg

☐ Other: _____

Emergency department visits in the last year? YES/NO (circle), Dates: _____

Oral Steroids in last year? YES/NO (circle),

Previous admissions for asthma? YES/NO (circle), Dates: _____

Previous intubation: YES/NO

Please indicate if previous Paediatrician involved:_____

Signature: _____ CPSO: _____