West Park HEALTHCARE CENTRE get your life back

REFERRAL FORM FOR RESPIRATORY REHABILITATION

Patient Name: _____

Address: _____

_____ DOB: _____

Home Telephone: _____ Cell: _____

Next of Kin Name: _____ Tel: _____

Health Card #: _____ Version Code: _____

Family Physician: _____ Tel: _____

Please fax this referral sheet along with the following documents:

Detailed, typed medical letter/medical summary stating reason for referral.
Relevant, available test results:

- ○ Pulmonary Function/Spirometry (PFTs)
- ○ Cardiac investigation
- ○ Arterial Blood Gases (ABGs)
- ○ Chest x-rays
- ○ Chest CT scan
- ○ Other Specialist Reports

✦ If referring from acute care, please **also** include the following:

Hospital discharge summary (if available) & current MAR (Medication Administration Record)
Complete online RM&R referral (if you have access)

Referring Facility: _____

Referring Physician: _____ OHIP Provider #: _____

Signature of referring Physician/Discharge Planner: _____

Doctor's office fax all documents to 416-243-3696

Acute Care facilities fax all documents to 416-243-3900

If you have any questions please call 416-243-3631