Community Airway Clinics – Langs CHC
Community Referral Form

Patient Name:	HCN:
Date of Birth:	Gender: ☐ Male ☐ Female
Parent Name (if applicable)	
Address:	
Phone:	Can a message be left? ☐ Yes ☐ No
Physician/Nurse Practitioner:	
Provider ID number (for Respirology report):	

Reason for Referral

☐ Spirometry (includes pre and post bronchodilator testing if appropriate, and oxygen saturation)	☐ Asthma Self-Management Education
☐ COPD Self Management Education	☐ Other:

Current Medications

Medications (including. Inhalers)	Dose	Frequency
Oxygen Prescription (if applicable)		

Relevant Medical History (please include previous spirometry or PFT results if available)

Signature of Referring Physician/Nurse Practitioner: ____________________

Date: ____________________

Please Fax form to Langs Community Health Centre, Attention Gabby Magliarisi: 519 653 6277

For Office Use Only

Appointment booked: ☐ Yes ☐ No Date/Time: ____________________

Patient Notified: ____________________