BC CHILDREN'S HOSPITAL
An Agency of the Provincial Health Services Authority

ASTHMA PROGRAM

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DATE: Patient Name DOB PHN # Phone number	Referring MD Address Phone Fax MSP #

□ **URGENT (reason):**
□ Routine
□ Interpreter required Language spoken:

REASON FOR REFERRAL

Please note that referrals for Asthma Education alone are no longer being accepted.
Please visit http://www.lung.ca/lung-health/get-help/ for other education clinics in your area.

Reason:

- □ Diagnosis unclear despite spirometry in children over 6, or supervised trial of treatment in children under 6
- □ Persistent symptoms despite daily moderate dose of inhaled corticosteroid
- □ Frequent and/or severe exacerbations despite daily moderate dose of inhaled corticosteroid
- □ Other

Specific clinical question/Expectations of the consultation:

Age when asthma was diagnosed:

RELEVANT PATIENT INFORMATION

THIS INFORMATION IS **CRITICAL** FOR YOUR PATIENT TO BE TRIAGED APPROPRIATELY

In the past 12 months: Number of courses of oral corticosteroids ___ Number of ER visits ___ Number of hospitalizations for asthma ___	ANY past ICU admissions _____ Other medical conditions _____ Psychosocial concerns _____

Current asthma medications (drug, dose, # inhalations & frequency)	In use since:
1. 2 3. 4.	

Past medications for asthma:

Relevant investigations, procedures, consultations (please attach results):

- □ Pulmonary function test □ Allergy consultation
- □ Chest x-ray □ Other

Other specialists involved in patient's care:

Please fax referral to (604) 875-3293