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)	
1. 2 3. 4.	
Past medications for asthma:	
Relevant investigations, procedures, consultations (please attach results): ☐ Pulmonary function test ☐ Chest x-ray	 ☐ Allergy consultation ☐ Other
Other specialists involved in patient's asthma care:	

Please fax referral to (604) 875-3653

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