

**REFERRAL CRITERIA**

- 1. Diagnosis of Asthma
- 2. 18 months or older
- 3. Family aware



**Asthma Education Clinic**  
 BC Children's Hospital, 4480 Oak Street, Vancouver  
 Asthma Education Clinic, Rm 1C31  
 604 875-2345 Local 7461; Fax 875-3653  
**Fax Referral to Certified Asthma Educator, RN**

**\*\*Please note: if your patient requires medical diagnosis and assessment, we will book them for our multidisciplinary Asthma Centre, which includes, Nurse Practitioners, CAE RN's, plus Pediatric Respiriologist and / or Pediatric Allergist**

Date of referral: \_\_\_\_\_  
 Referring Doctor: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Pediatrician: \_\_\_\_\_  
 Respirologist: \_\_\_\_\_ Allergist: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient's PHN number: \_\_\_\_\_ BCCH medical record #: \_\_\_\_\_

Parents'/Guardians' names: \_\_\_\_\_

Parents' home phone number: \_\_\_\_\_

Other phone numbers (work, cell): \_\_\_\_\_

Language spoken: \_\_\_\_\_ Interpreter required: \_\_\_\_\_

**Asthma History: (check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Recurrent asthma exacerbations             | <input type="checkbox"/> Asthma & school management      |
| <input type="checkbox"/> Education needed re: medications & devices | <input type="checkbox"/> History of Food Allergies _____ |
| <input type="checkbox"/> Asthma & sports                            | <input type="checkbox"/> History of atopy                |
| <input type="checkbox"/> Need PFTs                                  | <input type="checkbox"/> Anaphylaxis education           |

Other medical concerns: \_\_\_\_\_

**Please also send all reports relating to asthma - Hospital discharge summary, Allergy, Pulmonary function, Respirology.**

**Signature** \_\_\_\_\_