West Park HEALTHCARE CENTRE
Get your life back.

REFERRAL FORM FOR RESPIRATORY REHABILITATION

Patient Name: _____

Health Card #: _____ Version Code: _____

Date of Birth (Day/Month/Year): _____

Address: _____

Telephone (Home:) _____ (Cell:) _____

Next of Kin Name: _____ Tel: _____

Family Physician: _____ Tel: _____

Please fax this referral sheet along with the following documents:

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

- Respirology recent consult/clinic notes
- Pulmonary Function/Spirometry (PFTs)
- Arterial Blood Gas (ABG) (if available)
- Chest imaging (x-ray, CT)
- Cardiac investigations (if completed)
- Other relevant specialist reports

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

☐ Hospital OT/PT Ax & progress notes, discharge summary (if available) & current MAR
☐ Complete online RM&R referral (if you have access)

Referring Physician: _____ OHIP Provider #: _____

Referring Facility:_____

Signature (referring Physician/Discharge Planner): _____

Contact person name & phone number:_____

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

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

INCOMPLETE REFERRALS WILL NOT BE REVIEWED

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