ROSS MEMORIAL HOSPITAL
Kawartha Lakes

COPD Management Services Referral Form

Patient Name:	Health card #:
Phone (home): (work):	Address:
DOB:	Sex:
Family Dr: Fax: Phone:	Respirologist: Fax: Phone:

Reason for Referral/Comments:

☐ Recent ED Visit ☐ Recent Hospital Admission ☐ New or suspected diagnosis of COPD
☐ Education required ☐ Other: ____

Medications:____
____
____

Relevant History:

☐ Cardiac disease ☐ Neurological deficits ☐ Arthritis
☐ Other: ____

REFERRING PHYSICIAN NAME:____

REFERRING PHYSICIAN SIGNATURE: ______________________________ DATE: _______________

Please complete referral form and attach copy of most recent Spirometry/PFT and Action Plan (if available).

Fax to 705-328-6080.