Alberta Health Services

Calgary COPD & Asthma Program
Respiratory Education Referral

Inquiries: 403.944.8742

Patient Name _____
Address _____
City _____ **Postal Code** _____
DOB _____ **PHN** _____
Daytime Phone _____

Family Dr. Name _____
Family Dr. Office Phone _____
Family Dr. Office Fax _____

Note: This is a referral for respiratory education by a Certified Respiratory Educator. Patient will not be reviewed by a Respirologist. This assessment typically includes spirometry for diagnosis/management (unless contraindicated). If you **DO NOT** want your patient to have spirometry, please explain below:

Reason(s) for Referral: *(Patient must be 16 years and older)*

☐ Asthma ☐ COPD ☐ Smoking/Tobacco Reduction

Physician Comments/History

Requested Action(s):

☐ Confirm diagnosis
☐ Review and teach inhaler technique
☐ Suggest management
☐ Design and teach action plan related to asthma or COPD

Respiratory Medications

Attach if available: Pulmonary Function Test

☐ Language Barrier _____ ☐ Physical Limitation(s) _____

Referred by:

Referring Physician *(print name)* _____

Physician's Signature/Designate _____ **Date** *(yyyy-Mon-dd)* _____

Fax completed form to **403.476.7772**