Alberta Health Services

Alberta Children's Hospital

iCAN control asthma now

COMMUNITY PEDIATRIC ASTHMA SERVICE REFERRAL FORM

Date: yyyy/mmm/dd	Patient Information: (Patient label preferred)
PracID (required)➔	Last Name:
Referring Physician/Designate (required):	First Name:
	DOB: yyyy/mmm/dd Gender:
Clinic Name:	PHN:
	Address:
Address:	City: Province
	Postal Code::
Phone:	Best **Daytime Phone**:
Primary Provider:	
Parents/Guardian Names:	Interpreter required: No Yes
	Language:

IMPORTANT REFERRAL INFORMATION

CPAS Asthma Education Services, (CPAS) Calgary Zone	**Phone**: 403-943-9139	**Fax**: 403-776-3806

- ✓ Certified Respiratory Educators offer both in-person and virtual education appointments at various community clinics across the Calgary Zone. These sessions are designed for patients with non-urgent, mild to moderate asthma and include the development of a personalized Asthma Action Plan to support effective self-management. Wait times may be longer during the winter months.
- ✓ Spirometry is available for children aged 6 and older when appropriate. These tests may be performed during the appointment with an Asthma Educator. Referring physician **MUST** provide orders (see below) before we can proceed.
- ✓ For timely access to pediatric pulmonary function testing while awaiting CPAS education, consider also referring to the private pulmonary function labs. These facilities are equipped to assess children and may help bridge care during the interim until CPAS appointment.

Other Referral Options:
- ➔ Refer children <6 months to Pulmonary Clinic
- ➔ Refer moderate to severe children with asthma to Asthma Specialty Clinic

PATIENT CARE ORDERS

- In order for this referral to be processed, the following section **must be completed**
- Please note the orders below will cover both the initial and follow-up appointment

Yes	No		Yes	No	
☐	☐	**Spirometry**: Patient is 6 years or older and requires a Spirometry test	☐	☐	**Ventolin**: Dose: 4 puffs 100 mcg/puff Route: Inhaled Frequency: Once during initial appointment, once during follow up appointment

Physician Signature: _____

HISTORY: CHECK ALL THAT APPLY

Confirmed asthma diagnosis Yes ☐ No ☐

- ☐ Suspected asthma diagnosis based on history of wheeze with illness
- ☐ Family history of asthma
- ☐ Multiple visits to primary care physician for asthma or wheeze

In the last year, patient received _____courses of oral steroids

- ☐ ED visits or hospital admission for asthma or wheeze
- ☐ Needs more information about asthma

Other comments:

See Page 2 to add additional patient history or notes

Additional Patient History/Notes