NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

PAEDIATRIC RESPIRATORY CLINIC REFERRAL

Markham Site Booking Line: **(905) 472-7534**

Please Fax To: **(905) 472-7535**

Patient Name: _____ (Last) _____ (First)

Date of Birth: _____ (Day) _____ (Month) _____ (Year) Sex: F M

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Family Physician: _____

Date	**Referring MD**	**Signature**
Billing #	**Telephone**	**Fax**
Address	**City**	**Postal Code**

Additional Reports to:

Spoken Languange if other than English. **Please bring translator to the appointment if required.**

Request for

☑ Consult with Dr. S. Bola

Reason for Referral

- ☐ Known Asthma
- ☐ Recurrent pneumonia/pulmonary infections
- ☐ Chest Pain/Dyspnea on exertion
- ☐ Dyspnea/exercise intolerance
- ☐ Hemoptysis
- ☐ Other - please describe: _____
- ☐ Recurrent wheeze/Query asthma
- ☐ Chronic cough
- ☐ Query Sleep Disordered Breathing
- ☐ Complicated pneumonia follow-up
- ☐ Pneumothorax follow-up

Past Medical History

Current Medications

Has the patient had any of the following (if so, please attach reports)

- ☐ Pulmonary Function tests
- ☐ Methacholine challenge test
- ☐ Chest x-ray
- ☐ Chest CT
- ☐ Blood work for investigation of the chief complaint
- ☐ Sleep Study

Patient must bring a completed *Paediatric Respiratory Clinic New Patient Questionnaire* to their appointment.