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Description automatically generated**

Appointment Type Request

**□**In-person **□**Virtual

**Moncton Respirology Referral**

Prince Edward Island

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|  |  |
| --- | --- |
| **PATIENT INFORMATION** | **REFERRING PHYSICIAN/NURSE PRACTITIONER** |
| NAME | NAME |
| ADDRESS | ADDRESS |
| DOB | PHONE |
| HEALTH CARD | FAX |
| PHONE | REFERRAL DATE |
| EMAIL | EMAIL |

**Reason(s) for Referral:**

|  |  |  |  |
| --- | --- | --- | --- |
| **□**Asthma (mild/moderate) | **□**Dyspnea NYD | **□**Occupational Lung Disease | **□**Thromboembolic Disease |
| **□**Asthma (severe) | **□**Hemoptysis | **□**Pleural Disease | **□**Other |
| **□**Bronchiectasis | **□**Interstitial Lung Disease | **□**Scleroderma |
| **□**Cough NYD | **□**Lung Cancer/nodule | **□**Sarcoid |
| **□**COPD | **□**Neuromuscular Disease | **□**Sleep Disorder |

**Include recent relevant medical history: □**Consult notes **□**Medication list **□**Allergies/intolerances **□**Referral/Consult

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Severity of Symptoms:** **□**Severe **□**Moderate **□**Mild **□**Asymptomatic

**Urgency:** **□Urgent** (within 2 to 4 weeks) Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□Semi-Urgent** (within approximately 6 months)

**□Elective** (within approximately 6 to 12 months)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relevant Investigations** | **Date**  **(dd/mm/yy)** | **Attached** | **Ordered/**  **Pending** | **Comments** |
| Chest x-ray |  |  |  |  |
| Computed tomography (CT) |  |  |  |  |
| Pulmonary function test (PFT) |  |  |  |  |
| Lab work |  |  |  |  |
| Other relevant investigations |  |  |  |  |

**Has this patient been seen by a Respirologist before**? **□**No **□**Yes (please include previous notes and test results)

If yes, name of Respirologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date seen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician/NP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*This referral will be triaged by Respirology staff. Please ensure all sections are fully completed.**