# Referral Form
# Paediatric Respirology Clinic

Dr. Amy Glicksman, M.D. FRCPC
Lakeridge Health, 3rd Floor, A wing
1 Hospital Court, Oshawa, ON
Tel: 905−576−8711, ext. 32703
**Fax: 905−721−4857**

## Patient Information

Health Card Number: _____ Version Code: _____ DOB: _____

Last Name: _____ First Name: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

## Reason for Referral

☐ Asthma

Physician documented wheeze ☐ Yes ☐ No

ED Visits ☐ Yes ☐ No Last visit on: _____

Oral Steroids ☐ Yes ☐ No

Current medications: _____

Previous PFT ☐ Yes ☐ No **If YES, please include PFT Report**

☐ Recurrent pneumonia

Date(s) of illness: _____

**Please include all x−ray reports**

☐ Chronic cough

☐ Other (please describe): _____

Relevant history: _____

## Referring Professional

Name: _____ OHIP Billing Number: _____

Address: _____

City: _____ Postal Code: _____

Office Phone: _____ Fax: _____