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

Dates 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: ____