Lennox & Addington
County General Hospital

COPD Ambulatory Program
Referral Form

Outpatient Clinic

Tel: (613)354-3301 ext. 208; Fax: (613)354-4937

Patient's Name_____ Date of Birth (D/M/Y) _____

Address: _____Postal Code_____

Home Phone_____ Work Phone _____

Referring Physician_____

Referral Source: ER____ Outpatient___ Inpatient: LACGH: _____

Other: _____

Family Physician_____ Phone_____

Address_____

Reason for Referral: _____

Current Medication: _____

Past Medical History (include smoking & exposure history) _____

Pulmonary Function Results: Yes ____(please include results) No ____ Pending_____Date:_____
(if PFTs are required please fill out PFT referral form)

SERVICE REQUIRED:

☐ Clinic and Education Centre Assessment: _____
(Patient will be assessed by Respiratory Therapist and a plan of care will be developed with patient)

Urgency of Referral: 1 2 3 4 5
Urgent Elective

Physicians Signature: _____ Date: _____