Asthma Education Clinic – Referral Form

PATIENT INFORMATION:			
Date of Referral:			
Name:			
Home Address:			
Gender:		Date of Birth:	____ / ____ / ____ DD MM YYYY
Health Card # (including version code):		SH# (if available):	
Home Phone #:		Cell Phone #:	
Parent/Guardian:			
Preferred Language:	English ◯ French ◯		

REFERRING SOURCE:	
Name of referral source:	
Telephone number:	

HEALTH CARE PROVIDERS:	
Name of Family Physician/ Nurse Practitioner:	
Name of Pediatrician:	

Asthma Diagnosis Needed for Referral!

Date of Diagnosis: **Diagnosed By:**

Brief Medical History

Current Medications/Supplements:

Please note: All required information regarding the Asthma Education Clinic can be accessed at www.hsnsudbury.ca/NEOKids . **Please be sure to attach the patient's last clinical note and any recent lab/imaging results.** The patient will be contacted by the Pediatric ACU to have their appointment booked. Fax form to: **(705) 523-7288** or email form and attachments to neokidsacu@hsnsudbury.ca.