Respiratory Support Clinic Referral Form

St. Mary's General Hospital
911 Queen's Blvd.
Kitchener, ON, Canada
N2M 1B2
Tel: 519.744.3311

Patient Name: ______________________________ HCN#: ____________________

Date of Birth: ______________________________ Gender: □ Male □ Female

Contact Person/Power of Attorney (if applicable): ______________________________

Address: ______________________________

Phone (Home): ____________________ (Work): ____________________

Referring Physician/Nurse Practitioner: ______________________________

Family Physician: ______________________________

Reason for Referral: □ Consultation only

□ Consultation and Follow-up/Ventilator Care

Diagnosis

□ **Neuromuscular Disease** Specify: ______________________________

□ **Skeletal Disorder** (e.g. Kyphoscholiosis) Specify: ______________________________

□ **Obesity Hypoventilation**

□ **Overlap Syndrome** (e.g. COPD+OSAS+/- Obesity)

□ **Central Hypoventilation**

Previous History Information

□ **ABG's** Results pH _______ pCO_2 _______ pO_2 _______ HCO_3^- _______ Base Excess _______ FIO_2 _______

□ **Pulmonary Function Test** (please attach)

□ **CXR results** (please attach)

□ **Previous Consulations** (please attach)

□ **Medications:** ______________________________

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Specific Reason for Referral

□ **Invasive Ventilation**
□ **Non Invasive Ventilation**
□ **Lung Volume Recruitment**
□ **Non-Invasive Secretion Clearance**
□ **Tracheostomy change/management**
□ **Other:** ______________________________

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Signature of Referring Physician: ______________________________ Date: ____________________

PLEASE FAX REFERRAL FORM TO 519-749-6816
Please call the Airway Clinic at 519-749-6868 (option 1)
if you have any questions or concerns or visit our website: www.smgh.ca