



**Calgary COPD & Asthma Program
Respiratory Referral**
Administration Office:
#1633, 1632 – 14th Ave N.W.
Office Number: 403-944-8742

Name: _____
 Address: _____
 City: _____ Postal Code: _____
 DOB: _____ PHN: _____
 Patient Phone #: (H) _____ (W) _____
 GP's name must be filled in or referral will not be processed
 Family Dr: _____
 Office Phone: _____ Fax: _____

Patient must be 16 years and older

Date: _____

Asthma COPD Tobacco Reduction

Referred By: Physician Dr: _____ Healthcare Professional _____
 Emergency Department Self

Option #1: Education & Spirometry testing with a Certified Respiratory Educator.
 Preferred Community Clinics: North South

****Option 2 must be referred by a physician.**

Option #2: Referral to Respiriologist (includes education and spirometry testing with a Certified Respiratory Educator)

Preferred Site: Foothills Medical Centre (FMC)
 Peter Lougheed Centre (PLC)
 Rockyview General Hospital (RGH)

Referring Physician (please print clearly): _____
 Physician or Designate's Signature: _____

Medical History/Comments: _____

Please fax completed form to 403-283-3406



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