HARDIN RESPIRATORY CLINIC

Phone: (587) 276-5569
Fax: (780) 447-6575

PULMONARY & SLEEP REFERRAL FORM

#141 355 Loutit Road
Ft. McMurray, AB

PATIENT DEMOGRAPHICS (Please print or attach label)

PHN: _____ Date of Birth: _____ Sex: ☐ M ☐ F *Identify as:* _____

Last Name: _____ First Name: _____

Address: _____ City: _____ Postal Code: _____

Home Phone #: _____ Cell Phone #: _____

PULMONARY DIAGNOSTIC SERVICES

NORTHERN PULMONARY DIAGNOSTICS

☐ Pulmonary Function Test

☐ Spirometry

☐ DLCO (Spirometry Included)

☐ Other Services: _____

_____

SLEEP SERVICES

Respiratory Dynamics Sleep

☐ Sleep Apnea Testing and Treatment *(Includes HSAT (Home Sleep Apnea Test, Auto CPAP Trial and Treatment as indicated)*

☐ Home Sleep Apnea Test Only

☐ Direct to CPAP *(attach Sleep Study completed within past year)*

☐ Other Services: _____

REASON FOR REFERRAL/MEDICAL CONCERNS

☐ Fatigue ☐ Witnessed Apneas ☐ Occupational Concerns ☐ Snoring ☐ Asthma ☐ COPD

☐ ILD ☐ Dyspnea ☐ Screening ☐ Other: _____

PHYSICIAN INFORMATION

Additional Comment/Considerations: _____

Referring Physician: _____ PRAC ID: _____

Physician Signature: _____ Date of Referral: _____

Physician Phone: _____ Physician Fax: _____

FAX COMPLETED FORM TO: (780) 447 - 6575