THE LUNG CENTRE

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

The Lung Centre

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*Denotes Incorporation

Vancouver General Hospital
The Lung Centre (Respiratory Clinic) Referral Form
PLEASE FAX TO 604-875-4695

Date: _____

PATIENT NAME:_____

Address: _____

_____

Telephone: (h)_____(w)_____

PHN:_____ Date of Birth:_____

Refer to Doctor _____ **OR** • doctor with first available appointment

Reason for referral (please circle):

1. COPD
2. Asthma
3. Hemoptysis
4. Lung mass
5. Dyspnoea NYD
6. Cough NYD
7. Thromb-embolic disease
8. Bronchiectasis
9. Interstitial lung disease
10. COPD Clinic

Other (specify)_____

_____

Patient history:

_____

_____

_____

_____

Investigations: Where was the test performed?

Chest x-ray: YES / NO _____

CT Scan: YES / NO _____

Pulmonary Function Test: YES / NO _____

Lab work: YES/ NO _____

If yes, please fax the report(s) and/or other documents with this referral form.

Current Treatment:

_____

_____

_____

• contact patient with the appointment time **OR** • contact your office with the appointment time

REFERRING PHYSICIAN

NAME (print):_____ MSP No._____

Signature:_____ Telephone:_____

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