Respiratory Support Clinic Referral Form

St. Mary's General Hospital
Medical Center #2
435 The Boardwalk, Suite 306
Waterloo, ON N2T 0C2
226-896-2026

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 (if different from referring) : _____

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_____ FIO2_____

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

□ **CXR results** (please attach)

□ **Previous Consulations** (please attach)

□ **Medications:** _____

_____

_____

_____

Specific Reason for Referral

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

_____

Signature of Referring Physician: _____ Date: _____

PLEASE FAX REFERRAL FORM TO 226-896-2030
Please call the Airway Clinic at 226-986-2026
if you have any questions or concerns or visit our website: **www.smgh.ca**