Vancouver CoastalHealth LIONS GATE HOSPITAL

PEDIATRIC ASTHMA CLINIC REFERRAL FORM

FAX THIS FORM TO 604-984-3818

Please complete all section of this form. Your patient will receive a phone call with the detail of their scheduled appointment. For all enquires telephone 604-984-3830 or email ann.trenaman@vchc.ca

Patient details

Surname:_____ **Given Names:**_____

Date of Birth:_____ **Sex: Male Female**

Address:_____

_____

Preferred contact number: Mobile:_____ **Other**_____

Medical Number#:_____

Language Spoken at home:_____ **Interpreter Required: Yes____ No____**

CLINICAL DETAILS:

Reason for Referral / diagnosis:_____

_____

_____

_____

_____

Relevant Past History:_____

_____

_____

Medications:_____

_____

Relevant Pathology and imaging results:_____

_____

REFERRING DOCTOR DETAILS:

Surname:_____**-Given Name:**_____

Provider Number:_____

Telephone Number:_____ **Fax:**_____

Address:_____

Date:_____

Preferred Contact: Telephone____ Fax_____ Email_____