NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

PAEDIATRIC RESPIRATORY CLINIC REFERRAL

Markham Site Booking Line: **(905) 472-7534**
Please Fax To: **(905) 472-7535**

Patient Name: _____ (Last) _____ (First)
Date of Birth: _____ (Day) _____ (Month) _____ (Year) Sex: F M
Health Card # _____ Version Code: _____
Address: _____ Postal Code: _____
Telephone # (Best Daytime): _____
Alternate #: _____
Family Physician: _____

Date	**Referring MD**	**Signature**

Billing #	**Telephone**	**Fax**

Address	**City**	**Postal Code**

Additional Reports to:

Spoken Languange if other than English. **Please bring translator to the appointment if required.**

Request for

☑ Consult with Dr. S. Bola

Reason for Referral

- ☐ Known Asthma
- ☐ Recurrent pneumonia/pulmonary infections
- ☐ Chest Pain/Dyspnea on exertion
- ☐ Dyspnea/exercise intolerance
- ☐ Hemoptysis
- ☐ Other - please describe: _____
- ☐ Recurrent wheeze/Query asthma
- ☐ Chronic cough
- ☐ Query Sleep Disordered Breathing
- ☐ Complicated pneumonia follow-up
- ☐ Pneumothorax follow-up

Past Medical History

Current Medications

Has the patient had any of the following (if so, please attach reports)

- ☐ Pulmonary Function tests
- ☐ Methacholine challenge test
- ☐ Chest x-ray
- ☐ Chest CT
- ☐ Blood work for investigation of the chief complaint
- ☐ Sleep Study

Patient must bring a completed *Paediatric Respiratory Clinic New Patient Questionnaire* to their appointment.

MARKHAM STOUFFVILLE HOSPITAL

PAEDIATRIC RESPIRATORY CLINIC
NEW PATIENT QUESTIONNAIRE

Please complete the following and bring with you to your appointment.

Patient Name

1. Current Medical Concerns

☐ Cough ☐ Sleep Apnea ☐ Shortness of breath
☐ Wheezing ☐ Coughing blood ☐ Excessive snoring
☐ Other: _____

2. Previous Medical History

☐ Hospitalizations - Date/Reason: _____
☐ ICU admissions - Date: _____
☐ ER visits - average number ER visits per year: _____
☐ Other: _____

3. Travel History

_____

4. Immunizations

☐ Up to date
☐ Delayed, Reason: _____

5. Social History

☐ Current school grade: _____
☐ Number of absences from school in past year (for medical reasons): _____
☐ Pets in the household: How many? _____ Type: _____

6. Environmental

Y	N	
☐	☐	Carpet in house, Location: _____
☐	☐	Hardwood in house, Location: _____
☐	☐	Blind in bedroom
☐	☐	Drapes in bedroom
☐	☐	Air conditioning in house
☐	☐	Humidifiers in house
☐	☐	Dust mite covers used in house

7. Allergies

Drug allergies: _____

Other allergies: _____

8. Current Medications (please list)

Medication Name	Strength	Dosage	Frequency	How long taken?
Eg.: Flovent	50 mcg	2 puffs	2 times a day	3 months