Respiratory Care Group

Fax: (204) 725-3339
Toll Free: 1 (855) 774-6516
www.ranacaregroup.com

With You Every Breath of the Way

Community Respiratory Clinic Referral

Fax: (204) 725-3339

IMPORTANT RANA takes patient privacy seriously. Please include a blank fax cover sheet that does not contain any patient information with this referral.

Patient Information (Please Print or Affix Patient Label)

Patient Name (First, Last) ______________________

Street Address ______________________

____

Daytime Phone ______________________

Email Address ______________________

Support Person ______________________

Relation ______________________

Support Person Phone ______________________

Date of Referral ____ / ____ / ____ (DD / MM / YYYY)

PHIN (9-digit) ______________________

MHSC (6-digit) ______________________

Date of Birth ____ / ____ / ____ (DD / MM / YYYY)

Gender ☐ M ☐ F Identifies as ______________

Referral is a Result of

☐ MD Visit ☐ Hospital Visit ☐ ER Visit ☐ Pharmacy Visit ☐ Other ____________

Reason for the Referral is

☐ Assessment
☐ Education
☐ Delivery Devices
☐ Spirometry with Pre/Post Bronchodilation
☐ Exercise Pulse Oximetry
☐ Follow-up new therapy
☐ Follow-up post discharge
☐ Follow-up post ER visit
☐ Other ____________

Objective ____

____

Medical History

Respiratory Diagnosis ____

____

Severity of Disease: ☐ Mild ☐ Moderate ☐ Severe

Level of Urgency: ☐ **Low** ☐ **Medium** ☐ **High**

If the patient has been diagnosed with asthma, do they have an Action Plan? ☐ Y ☐ N

Other Medical Diagnosis ____

____

Medications	Drug	Dosage	Drug	Dosage	Drug	Dosage
Bronchodilators	☐ Salbutamol		☐ Atrovent		☐ Combivent	
Long Acting BD	☐ Incruse		☐ Anoro		☐ Spiriva	
Steroids	☐ Pulmicort		☐ Flovent		☐ Prednisone	
ICS/LABA	☐ Breo		☐ Symbicort		☐ Advair	
Leukotrienes	☐ Antibiotics		☐ Singulair		☐ Oxygen	
Other	☐		☐		☐	

Referring Physician Authorization (Please Print or Affix Clinic Label)

Name ______________ Practice ID ____________

Clinic Name ______________________

Address ______________________

Phone ____________ Fax ____________ Signature ____________

RANA Office Use Only Date Referral Received ____ / ____ / ____ (DD / MM / YYYY) Date Client Contacted ____ / ____ / ____ (DD / MM / YYYY)

Clinic Appt Date ____ / ____ / ____ (DD / MM / YYYY) Clinic Location ______________ Client Refused Service ☐