



Religious Hospitallers
of Saint Joseph
of the Hotel Dieu of Kingston
HOTEL DIEU HOSPITAL

Chronic Obstructive Pulmonary Disease (COPD) Clinic Referral

Telephone: 613-544-3400 Ext. 2832

Fax: 613-548-1359

Internet: www.hoteldieu.com

Patient Name: _____

Health Card # _____

Date of Birth (yyyy/mm/dd): _____

Address: _____

Phone - Home: _____

- Work: _____

Urgency of referral:

Urgent Semi-urgent Elective

Referral date (yyyy/mm/dd): _____

Appointment date (yyyy/mm/dd): _____

Referring practitioner: _____

Referring practitioner signature: _____

Referral Source: Family Practice Emergency Department Outpatient Inpatient

Reason for referral: _____

Service(s) requested: *(check appropriate box)*

- Clinical assessment & optimization of treatment
- COPD self-management education
- Assessment for pulmonary rehabilitation

~~ NOTE: to confirm COPD diagnosis, please arrange pulmonary function testing ~~

Location of test results:

- Patient Care System (PCS)
- Attached
- Pending

Health history: *(check appropriate box)*

Current smoker: No Yes Smoking history _____ packs _____ years

Occupational exposure: No Yes, if yes explain: _____

Adverse reactions: No Yes, if yes list: _____

Currently using inhalers: No Yes, if yes list: _____

Additional health history: _____

FAX Referral to the COPD Clinic - Fax # 613-548-1359

Please inform patients that they will:

- Be contacted by the Hospital with the appointment date and time.
- Need to bring their health card and medications with them.