CareicaHealth

Toll Free: 1-855-774-6156
Fax: 204-725-3339
CareicaHealth.com

Community Respiratory Clinic Referral

IMPORTANT Careica 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 _____

Support Person _____

Support Person Phone _____

Date ____ (DD) ____ (MM) ____ (YYYY)

PHIN (9-digit) _____

MHSC (6-digit) _____

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

Gender ☐ M ☐ F ☐ Identifies as _____

MEDICAL HISTORY

Respiratory Diagnosis _____ (Required)

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	☐		☐		☐	

REFERRAL IS A RESULT OF

☐ MD Visit ☐ Hospital Visit ☐ ER Visit ☐ NP ☐ 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 _____

REFERRING PHYSICIAN AUTHORIZATION (Please Print or Affix Clinic Label)

Name _____ Practice ID _____

Clinic Name _____

Address _____

Phone _____ Fax _____ Signature _____

Careica 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 ☐