Park Integrative Health

REFERRAL FORM

PATIENT INFORMATION		REFERRING PHYSICIAN INFORMATION	
Name:		**Physician:**	
PHN:	**DOB:**	**PracID:**	
Address:		**Clinic Name:**	
City/Province/Postal Code:		**Address:**	
Phone:		**Phone:**	**Fax:**
Email:		**Physician Signature**	

PULMONARY FUNCTION REFERRAL		LONG COVID-19 CONSULTATION	
☐ Asthma Screen / Evaluation	☐ Chest Pain	☐ Depression/Anxiety	☐ Distractibility/Difficulty focusing
☐ COPD Screen / Evaluation	☐ Pneumonia	☐ Rapid Weight Loss/Gain	☐ Neuropathy
☐ Smoker: Current / Former	☐ Abnormal CXR / CT	☐ Fatigue Brain Fog	☐ Palpitations
☐ Cough/Wheeze	☐ Interstitial Lung Disease	☐ Memory Impairment	☐ Low Appetite
☐ Shortness of Breath	☐ Pre-Surgery	☐ Muscle Aches/Cramps	☐ Lack of Smell / Taste
☐ Pre-Employment	☐ Annual	☐ Other:	

PULMONRY FUNCTION TESTING REQUEST
☐ Spirometry - *may include bronchodilator*
☐ Pulmonary Function Testing – *includes Spirometry, Lung Volume Measurements, Diffusion Capacity, +/- Bronchodilator*
☐ Spirometry and Diffusion Capacity – *may include bronchodilator*

CONSULTATION REQUEST
☐ Long COVID-19 Consultation
☐ Internal Medicine Consultation
☐ Adult Sleep Consultation
☐ Adult/ Pediatric Allergy Testing
☐ Pediatric Respirology Consultation
☐ Pediatric Sleep Consultation

HISTORY / COMMENTS

MEDICATIONS

PLEASE FAX TO PARK INTEGRATIVE HEALTH: 780-570-8490.

970, 3890 Sherwood Drive Sherwood Park, AB T8H 0Z9
P: 780-570-8480 F:780-570-8490
pihealth.ca