Grand Bend Area CHC

Better Breathing Team Referral Form

Grand Bend Area Community Health Centre
Every One Matters.

Better Breathing Team

Patient Name: _____ Health Card #: _____

Date of Birth: _____ Referral Date: _____

Address: _____ Practitioner Name: _____

Address line 2: _____ Practitioner Phone: _____

Phone: _____ Practitioner Fax: _____

Key Details of Respiratory Illness

_____

_____

_____

_____

☐ Mild
☐ Moderate
☐ Severe

☐ Recent ER Visit
☐ Recent Hospitalization
☐ Ongoing Exacerbation
☐ Recent Respiratory Infection

Relevant Medical/Social History

_____

_____

_____

_____

Urgency of Referral

☐ Low ☐ Moderate ☐ High

Smoking History

☐ Never Smoked ☐ Quit in the past ☐ Currently smoking

By signing below, you authorize the Better Breathing Team to:

Perform spirometry and/or initiate client participation in a pulmonary rehabilitation program (inclusive of both education and exercise) unless otherwise contraindicated

Program Notes:

1. The mandate of the Better Breathing Team is to maximize client's self-management of chronic lung disease through education/exercise, optimal pharmacotherapy, home safety assessments, and the use of action plans. Referrals may be made to other Allied Health professionals as warranted
2. Spirometry results (interpreted by Dr. C. Licskai, Respirologist) will be sent to you for your files

Referring Practitioner Signature: _____ **Date of Referral:** _____

Please return referrals and/or direct questions to the GBACHC Better Breathing Team
Box 1269, 69 Main St. E., Grand Bend, ON N0M 1T0 Phone: 519-238-1556 x282 or x284 • Fax: 519-238-6478