

Meridian Grove Respiratory Clinic

Respirology & Lung Care | Peterborough, Ontario
176 Ferncross Boulevard, Ground Floor - Fictional address
Phone 705-555-0109 | Fax 705-555-0139
referrals@meridiangrove.example

REFERRAL REQUEST

Please complete all relevant fields and attach supporting reports.

PATIENT INFORMATION

Legal name:		Date of birth (YYYY-MM-DD):	
Health card number:		Version code:	
Address:		City / postal code:	
Primary phone:		Alternate phone:	
Preferred language:		Pronouns (optional):	

REFERRING CLINICIAN

Clinician name:		Billing / licence number:	
Clinic / organization:		Secure email:	
Phone:		Fax:	
Signature:		Date:	

REASON FOR REFERRAL

Priority: ☐ Routine ☐ Urgent - clinical rationale required below

Primary clinical question:

Relevant symptoms, duration, and functional impact:

CLINICAL INFORMATION

Relevant medical and surgical history:

Current medications and allergies:

Investigations attached: ☐ Laboratory ☐ Imaging ☐ Consultation notes ☐ Other

Additional information:

SERVICE-SPECIFIC NOTES

Common referral areas: Asthma, COPD, Chronic cough, Exertional dyspnea, Bronchiectasis.

Submission guidance: A referral is required. Include the reason for referral, smoking and occupational history, current inhalers, chest imaging reports, pulmonary-function results, oxygen saturation, and recent exacerbation history.