VAUGHAN COMMUNITY HEALTH CENTRE

Vaughan Chronic Obstructive Pulmonary Disease (COPD) Program Self- Referral Form

9401 Jane St, Ste. 206, Vaughan ON, L6A 4H7
Phone: 905-303-8490 ext. 2 Fax: 905-303-0320

Client Information

Last Name	First Name	❑M	❑F	❑Other:
Date of Birth (YYYY/MM/DD):	OHIP#: ❑ Non-Insured:			Expiry Date (MM/DD):
Address:				
Primary Phone #: Secondary Phone #:		Preferred Language:		
Preferred Method of Contact: ❑ In-person visits – ❑ Vaughan – ❑ Keswick ❑ Virtual Consult – Telephone OR ❑ Video (Ontario Telemedicine Network)				

Reason For Referral

❑ I am diagnosed with Chronic Obstructive Pulmonary Disease (COPD)

❑ Chronic Bronchitis — When were you diagnosed with COPD?

❑ Smoking Counseling — ❑ Diagnosed with Emphysema

❑ Recent Discharge from Hospital — ❑ Diagnosed with other lung disease

Do you have or have you ever experienced any of the following (please check all that apply):

❑Regular coughing ❑Coughing up phlegm ❑Easily getting out of breath ❑Wheezing when I exert myself

❑Getting many colds, typically lasting longer than average.

Relevant History ❑ Previous COPD education ❑ Home oxygen therapy; Flow:

❑ Recent hospitalization; Date: ❑ Recent exacerbation; Date:

Spirometry Results:

I recently completed spirometry/PFT with my family MD/specialist ❑yes ❑ no

Family Physician Contact Information:

Name: **Address:** **Phone:** **Fax:** **Billing Number:**	❑ **I authorize the staff from the Vaughan CHC to contact my family physician to obtain records of my most recent test results or medications** **Client Signature:** **Date:**