FAX PATIENT REFERRAL TO:
REFERRAL MANAGEMENT SERVICES
FAX: 1-855-355-1921
PHONE: 1-833-337-7770

ADULT RESPIROLOGY AND SLEEP MEDICINE: SASKATOON

(Division of Respirology and Sleep Medicine in Saskatoon will accept referrals for patients aged 17 and older).

ALERT – For Emergent Referrals Contact SFCC 1-866-766-6050

PATIENT INFORMATION:	Last Name:		First Name:
Date of Birth: DD/MMM/YYYY	Age:	Address:	
City:	Prov:	PC:	HSN:
Home Phone:	Work Phone:	Cell Phone:	
Requires Interpreter ☐ YES ☐ NO	Language:	Gender ☐ M ☐ F ☐ Other ☐ Undeclared	

REFERRING PRACTITIONER & CLINIC INFORMATION:

☐ Family Doctor ☐ Nurse Practitioner ☐ Specialist ☐ Other (Specify) _____	Name: Address: Phone: Fax:	☐ **URGENT** (Explain and attach supporting information): URGENCY IS TRIAGED BY SPECIALISTS' OFFICE

REFERRAL TO:

☐ Next Available Specialist **Except Dr.** _____	☐ Specific Dr. _____	☐ Previously seen Respirologist: _____

REASON FOR REFERRAL: CHECK PRIMARY REASON FOR REFERRAL AND INCLUDE RELEVANT DOCUMENTATION.

Respirology/ Sleep Medicine	☐ Pulmonary Nodule/Mass/Lesion ☐ Cancer or Highly Suspicious for Cancer ☐ Pleural Effusion ☐ Thoracic Lymphadenopathy ☐ Stridor ☐ Shortness of Breath/Cough/Wheeze ☐ COPD ☐ Asthma ☐ Acute Airways Clinic (ONLY for asthma or COPD patients being discharged from ER or Hospital) ☐ Cystic Fibrosis ☐ Non-Cystic Fibrosis Bronchiectasis ☐ Interstitial Lung Disease (ILD)	☐ Sarcoidosis ☐ Pulmonary Hypertension (Echo required) ☐ Pulmonary Vasculitis ☐ Central Airway Disease ☐ Hypoventilation ☐ Respiratory Muscle Weakness/Neuromuscular disease ☐ Hereditary Hemorrhagic Telangiectasia (HHT) ☐ Abnormal Pulmonary Function Test Results ☐ Narcolepsy ☐ Parasomnia ☐ Central Sleep Apnea/Obstructive Sleep Apnea ☐ Other: _____

For Triage Purposes: (provide detailed information explaining patient complexity, comorbidities, and/or previous specialist consults, Spirometry/PFT, Sleep testing, Chest Imaging *OR* attach information in letter) REFERRAL EXPLANATION IS A MANDATORY REQUIREMENT TO TRIAGE REFERRALS

Previous Investigations	Attached	Pending/Ordered	Previous Investigations	Attached	Pending/Ordered
Chest X-Ray	☐	☐	Lab work	☐	☐
Computed Tomography (CT)	☐	☐	Spirometry/PFT	☐	☐
Other Relevant Investigations	☐	☐	List Investigations:		

POOLED REFERRAL INFORMATION: Patients offered the pooled referral option will receive the next available appointment with a specialist able to treat the referring condition. This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improve the patient experience.

Physician Signature:	Date:
Redirecting Specialist: ☐ Pooled ☐ Specific Dr.	Date: