Pulmonary Rehab – Central Access Referral Form

Patient Name:	Date:
PHN:	Pulmonary Diagnosis:
DOB:	Patient Address:
Home Phone:	Mobile Phone:

Required Diagnostic Reports (please attach):

☐ **Pulmonary Function Test (within 12 months)**

Referral Source Contact Information

Family Physician:
Family Physician Phone:
Family Physician Fax:

If different from above, please complete:

Referring Physician Name:
Referring Physician Phone:
Referring Physician Fax:

Other information or comments:

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Fax form to: Central Access Fax: 780-670-3235 Phone: 780-735-3489

Revised December 28, 2023