RFLA Allied Health Team
Referral Form

Patient Information

Last Name:		First Name:		Sex:	
Address:			City:		
Postal Code:		Home Phone:		Alt. Phone	
Date of Birth:		Health Card / VC			

Allied Health Professional(s) Service Requested

	Professional	Comment
☐	Social Worker	
☐	Practical Assistance Worker	
☐	Dietitian	
☐	Respiratory Therapist ☐ Spirometry pre & post bronchodilator	

Reason for Referral

Patient Eligibility and Consent

☐	Patient does not have private insurance for this service
☐	Patient has provided consent to be contacted by phone and have voicemails left
☐	There are special considerations for this patient (e.g.: not a candidate for group visits). Please contact referring physician for detail

Patient's Preferred Location of Service

☐	Referring physician office	☐	Lenadco 310 Bridge St. Napanee	☐	Other:

Referring Provider Information

Phone:		Fax:		Date:	
Last Name:		First Name:			
Signature:					

Please fax referrals to: 855-940-4921