# CHRONIC-COUGH CANADA

1200 Main Street West,
Hamilton, ON, L8N 3Z5

https://www.chronic-cough.ca
info@chronic-cough.ca
**FAX: (905) 521-5053**

**REFERRAL DATE:**

## PATIENT INFORMATION

| | | |
|---|---|---|
| LAST NAME | FIRST NAME | HC# |
| ADDRESS | | DATE OF BIRTH |
| HOME PHONE | WORK PHONE | GENDER |

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| REFERRING PHYSICIAN | ADDRESS | PHONE<br>FAX |
| ☐ SEND COPY OF RESULTS TO | | |
| NAME OF PHYSICIAN: | ADDRESS | PHONE<br>FAX |

## REASON FOR REFERRAL – THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE BOOKED

| | | |
|---|---|---|
| **COUGH DURATION:**<br>WEEKS/MONTHS/YEARS | **TYPE OF COUGH:**<br>☐ DRY ☐ PHLEGM | **SMOKING STATUS:**<br>☐ CURRENT ☐ FORMER ☐ NEVER |

**RED FLAGS:**
☐ WEIGHT LOSS ☐ HEMOPTYSIS ☐ FEVER ☐ ABNORMAL CXR ☐ NONE

| | |
|---|---|
| **ACE INHIBITOR:**<br>☐ YES ☐ NO ☐ | **COUGH SEVERITY:**<br>☐ MILD ☐ MODERATE ☐ SEVERE |

**HISTORY/CLINICAL SUSPICION OF:**
☐ ASTHMA ☐ COPD ☐ UPPER AIRWAY COUGH SYNDROME ☐ REFLUX ☐ NONE

**ADDITIONAL NOTES/RELEVANT MEDICAL HISTORY:**

## ADDITIONAL TEST(S) REQUESTED

| | |
|---|---|
| ☐ COMPLETE PULMONARY FUNCTION TEST (PFT) | ☐ EXERCISE TEST |
| ☐ SPIROMETRY | ☐ METHACHOLINE CHALLENGE TEST |
| ☐ SPIROMETRY (with Reversibility Assessment) | ☐ CHEST X-RAY |

## FOR CLINICAL OFFICE USE ONLY:

**NOTES:**

**TRIAGED BY: _____** ☐ **URGENT** ☐ **NOT URGENT**