Access & Triage Form

Referrals will be accepted without this form when a typed or EMR-generated consult request is provided.
Using this form as a guideline for information to be included assists us in providing timely and appropriate service.

MISSISSAUGA LUNG HEALTH CENTRE

214- 89 Queensway West
Mississauga, ON L5B 2V2
Tel. 905-848-6079
Fax 905-858-8835

Patient Information: *(Affix label)*

Surname: _____ Given name(s): _____

Health Card #: _____ Version: _____

Address: _____

_____

Tel #: _____ Alternate #: _____

Referring Provider: *(Name/ fax/ email or Stamp)*

***Date of Referral:**

Provider Number:

***Refer to:** *(Note: we do NOT provide Sleep Medicine consultation at this time)*

- ☐ First Available, ***or***
- ☐ Dr. Milan V. Patel, MD, FRCP(C)
- ☐ Dr. Sarah Nelson, MD, FRCP(C)
- ☐ Dr. Revital Wanono, MD, FRCP(C)
- ☐ Dr. Nooreen Mann, MD, FRCP(C)
- ☐ Dr. Deepti Damaraju, MD, FRCP(C)

***Signature:**

Type of referral:

- ☐ New Referral
- ☐ Re-referral
- ☐ 2nd opinion
- ☐ Transfer of respirology care (explain below)
- ☐ Other: _____

***Urgency of referral:** *(Each case is triaged based on clinical information provided)*

- ☐ Emergency *(Call office **or** discuss with base hospital Respirologist on-call **or** send patient to ER)*
- ☐ Urgent *(< 1 week)*
- ☐ Semi Urgent *(1- 4 weeks)*
- ☐ Routine *(4-12 weeks)*

Requested Action (select all that apply):

- ☐ Spirometry testing, and consultation if abnormal
- ☐ Confirm / advise as to diagnosis
- ☐ Suggest management / medication
- ☐ Assume management and return patient after care
- ☐ Assume future (respiratory) management of patient

***Reason for Referral:** *(Include relevant past medical history & medications, **or** attach records)*

Requirements for Triage: *(when available)*

- ☐ Relevant primary care notes or treatment trials
- ☐ Diagnostic imaging/ cardiac tests/ reports
- ☐ Relevant/related consultation letters (eg cardio/sleep/allergy/ENT/rheum)
- ☐ Recent labs (ie. CBC / Creatinine)

Factors that may impact care plan:

- ☐ Non-English speaking: _____
- ☐ Cognitive impairment: _____
- ☐ Transportation: _____
- ☐ Economic: _____
- ☐ Psychosocial: _____
- ☐ WSIB, LTD or other insurance-related referral?

Notification of receipt of this form and/or patient appointment will be provided within 3 business days.
***For urgent cases, please call the office to follow up on booking.**