

## Community Asthma Care Centre

Patient name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Telephone Number(s): (H) \_\_\_\_\_ (B) \_\_\_\_\_  
Health Card number: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Please check one:

- Asthma Education Only**  
 **Asthma Education and Respiriologist/Pediatrician consult**

Referring physician signature: \_\_\_\_\_  
Date of referral: \_\_\_\_\_

**\*\*ALL VISITS REQUIRE AN APPOINTMENT\*\***

**Please fax referrals to 905-704-4756**  
Or call 905-378-4647 ext. 46502 for an appointment

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Niagara Health