



Optimizing Chronic Disease Management

Asthma Program  
Emergency Department  
Referral

Royal University Hospital  
Saskatoon, SK S7N 0W8  
Phone: (306) 655-6781  
Fax: (306) 655-6758

**Client Information**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ PHN: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

**History**

1. Level of Asthma Severity:  Mild  Moderate  Severe ( If known)

2. Present Medications & Dosages: \_\_\_\_\_

\_\_\_\_\_

3. Other pertinent health history: \_\_\_\_\_

\_\_\_\_\_

4. Admitted to hospital?  No  Yes If yes- date of admission: \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd mm yy

5. Date visited the Emergency Room \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd mm yy

6. Patient aware of referral?  Yes  No

\_\_\_\_\_

**The Asthma Educator will contact the patient by phone upon receiving this referral.**

**Fax completed form to: (306) 655-6758**

