



Queensland
Government

Attention: CENTRAL INTAKE UNIT
Address: P O BOX 52 INALA Q 4077
Phone: (07) 3275 5411
Fax: (07) 3278 7086

REFERRAL TO: BRISBANE SOUTH RESPIRATORY SERVICE

To access the service please complete the referral details below and forward by fax or mail to the above contact details. An alternative form, which includes the same information e.g. RACGP form, may be used if preferred. Phone referrals are also welcome.

CLIENT DETAILS

Referral Date: ____/____/____ Preferred Title: Mr Mrs Ms Miss

Name: _____ Male Female

Address: _____ DOB: ____/____/____

Phone: _____

Mobile: _____

Indigenous Status: Aboriginal Torres Strait Islander Both Neither Not Stated

Country of Birth: _____ Language: _____

Interpreter required: Yes No

Doctor: _____

Phone: _____ Fax: _____

REFERRAL REASON

Home Oxygen Pulmonary Rehabilitation Pulmonary Maintenance

Asthma COPD Other

Relevant Medical History (or provide medical report): _____

Spirometry Date: ____/____/____ Results: { FEV _____
FVC _____
FEV/FVC _____

Medications: _____

Pulmonary Rehabilitation Finish Date: ____/____/____

Outcome Measures: 6MWT _____ SGRQ _____

Name of Referrer: (please print or stamp) _____

Address: _____

Phone: _____ Date: ____/____/____