DR. MICHAEL MITAR

MD, FRCPC

Respirologist

AVIVA
MEDICAL SPECIALISTS CLINIC INC.

RESPIROLOGY REFERRAL

Please check all that apply: Is the patient currently on Oxygen? ❑ No ❑ Yes

❑ Cough ❑ Asthma ❑ Hemoptysis ❑ Abnormal Imaging

❑ Dyspnea ❑ COPD ❑ Pulmonary Fibrosis ❑ Pulmonary Hypertension

❑ Other (specify): _____

**** Please provide all relevant imaging and blood work with referral.***

Current Medications (List or attach) _____

_____

_____

PATIENT INFORMATION - PLEASE COMPLETE

Patient's Last Name:	First:	❑ Mr. ❑ Mrs. ❑ Ms.
Home Address:	City:	Postal Code:
Email Address:	Home Phone:	Mobile Phone:
Date of Birth:	OHIP Number:	

REFERRING PHYSICIAN - PLEASE COMPLETE

Referring Physician (PRINT) _____ Backline Number: _____

Address: _____ Fax Number: _____

Physician Signature: _____ CC to Family Doctor (if different): _____

Billing Number: _____ Family Doctor Phone: _____

Please Note: Our office will contact your patient with an appointment date and time
Call or email us if you would like any information at anytime. Contact us at referrals@avivamedical.com or at the numbers below. All consult notes will be sent to your office via fax after each patient visit.

**** Copies of this Referral form can be downloaded on our website at www.avivamedical.com***

PLEASE FAX ALL REFERRALS TO THE CENTRAL BOOKING LINE

Toll Free Fax Line: 1-855-210-0758 • Local fax line: 905-662-3304

180 Vine Street St. Catharines, Ontario L2R 7P3 | (Suite 201)

LOCAL MAIN LINE: 905-662-3303
TOLL FREE MAIN LINE: 1-855-210-0757

LOCAL BACKLINE: 905-662-3263
TOLL FREE BACK LINE: 1-855-210-0707

* BACK LINE FOR PHYSICIANS ONLY *