KINGSTON RESPIRATORY SERVICES

725 Arlington Park Place (Unit 3)
Kingston Ontario K7M 7E4
PHONE: (613) 544-7910
FAX: (613) 542-0746
kingstonrespiratoryservices.com

REQUISITION

Office Use:

Physician/NP Name:
Office Address:
Tel:
Fax:
MOH Billing #:
Copy Report to:

SIGNATURE: _____

Date (DD/MM/YY): _____

PATIENT INFORMATION

Name:
Address:
Tel: (H)
(C)
Date of Birth: ☐ M ☐ F
Health Card: VN:

OR AFFIX STICKER

☑ Alpha-1-Antitrypsin Deficiency Clinic Referral

☐ Current Serum Alpha-1-Antitrypsin level: _____ g/L (must be < 1.13g/L for referral)

OR

☐ COPD Diagnosed in a patient <65 years of age (FEV1/FVC < 0.70 on spirometry)
☐ COPD Diagnosed in a patient with <20 pack year smoking history (Est Pack Yr: _____)

Other relevant details: _____

***** Please include bloodwork showing A1AT serum level with referral (If available). Any other available PFT/Spirometry reports, clinic notes/medication lists and prior thoracic imaging are also helpful *****

Clinic Purpose/Goals:

- Facilitate genotyping of alpha-1-antitrypsin deficiency alleles
- Respiratory optimization, risk reduction strategies with A1AT, counselling on screening family/children, referral for augmentation or transplant if needed
- Screening for other manifestations of A1AT (hepatic, renal, dermatologic etc), referral to relevant subspecialists as required
- Assistance with accessing patient support/information materials, enrollment with clinical trials if patient is interested