PHYSICIAN REFERRAL
OUT-PATIENT
PULMONARY REHABILITATION
PROGRAM

Freeport Campus, Grand River Hospital
3570 King Street East, Kitchener, Ontario, N2A 2W1
PHONE: 519-749-4300 ext. 7309    FAX: 519-894-8307

Referral criteria for the Pulmonary Rehabilitation Program:
1. Pulmonary disease that is functionally limiting despite maximal medical therapy.
2. Motivated to participate in an education and exercise program.
3. Non-smoking.
4. No contraindications to cardiovascular exercise.

**RESPIROLOGY ASSESSMENT IS MANDATORY BEFORE ENTRY**

Respirologist:
1. Assures appropriateness / safety for Program/supervised exercise.
2. Reviews general expectations.
3. Completes all fields on the admission form, and attaches all relevant reports.
4. Forwards the completed form to the address or number above.

<table>
<thead>
<tr>
<th>Patient Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Home ph. #</td>
</tr>
</tbody>
</table>

Diagnoses:

- None Known
- Drug Allergies
- Food or Environmental

Smoking history:
- □ Never
- □ Quit date: _
- Total pack-years smoked: _

Oxygen use:
- □ None
- Flow rate: _
- Rest: _
- Exertion: _
- QIS: _

Test Results which must accompany referral:

- □ MANDATORY-Consult Notes report attached
- □ MANDATORY-Pulmonary Function Tests report attached
- □ Arterial blood gases (if done) report attached
- □ ECG report attached
- □ ECHO report attached
- □ Cardiology Assessment &/or Exercise Stress Test if done report attached

Blood work if available:

Cardiopulmonary Exercise Test (CPET)

CPET booked (date) ____________
(Year – Month – Day)

If CPET not done, the referring respirologist verifies the patient is safe to proceed with progressive exercise program □
ADVANCE DIRECTIVE DISCUSSED  YES □  NO □

PLEASE INDICATE SPECIFICS OF DIRECTIVE:

<table>
<thead>
<tr>
<th>Physician Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Physician:</strong></td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Respirologist:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Signature:</td>
</tr>
</tbody>
</table>

Specific medical or other concerns to be addressed in the Program (attach pages if needed) (e.g. sputum clearance, falls, weight management, lung transplant)