# 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.

## Patient Identification

| Last Name | First Name | Initial | Birth date (Y/M/D) |
|---|---|---|---|
| Street Address | | | |
| City | | Prov. | Postal Code |
| Home ph. # | Cell ph. # | Health # | Gender |

| | | | | | |
|---|---|---|---|---|---|
| Diagnoses: | | | | | |
| Allergies: ❒None Known ❒Drug Allergies _____ ❒Food or Environmental_____ | | | | | |
| Smoking history: | ☐ Never | Quit date: | | Total pack-years smoked: | |
| Oxygen use: | ☐ None | Flow rate: | Rest: | Exertion: | QHS: |

| **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)<br><br>CPET booked (date) _____<br>(Year –Month–Day)<br><br>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:** | |

| **Physician Information** | | | |
|---|---|---|---|
| **Family Physician:** | | | |
| Name: | Phone # | Fax # | |
| Address: | City | Postal Code | |

| **Respirologist:** | | | |
|---|---|---|---|
| Name: | Phone # | Fax # | |
| Address: | City | Postal Code | |
| Signature: | Date: | | |

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