WRHN
Waterloo Regional Health Network

PULMONARY REHABILITATION PROGRAM
Outpatient Referral Form

WRHN @ Chicopee, Union Terrace 1st Floor
3570 King Street East, Kitchener, Ontario, N2A 2W1
Phone: 519-894-8340 Fax: 519-894-8307

PULMONARY REHABILITATION REFERRAL CRITERIA:

For the referral to be considered, the following criteria must be met:

- ❑ Pulmonary disease that is functionally limiting despite maximal medical therapy.
- ❑ Motivated to participate in an education and exercise program
- ❑ Non-smoking
- ❑ No contraindication to cardiovascular exercise.
- ❑ Assessment by Respirologist completed as it is MANDATORY before entry into the program.

Respirologist:

- ✓ Assures appropriateness/safety for program/supervised exercise.
- ✓ Completes all fields on the referral form, and attaches all relevant reports.
- ✓ Reviews general expectations.
- ✓ Forward the completed referral form to the address or fax number above.

Patient Identification

Last Name:	First Name:	Middle Initial:	Birth Date: (year/month/day)
Address:	City:	Province:	Postal Code:

Birth Sex: ❒Male ❒Female ❒Other_____ Gender: ❒Male ❒Female ❒Other_____

Home Phone #:	Cell Phone #:	Health card #: Expiry:	Version Code:

Alternate Contact ❒Emergency Contact ❒Substitute Decision Maker (SDM) ❒Power of Attorney

Last Name:	First Name:	Relationship:
Home Phone #:	Business Phone #:	Cell Phone #:

To arrange appointments contact: ❒Patient ❒Alternate Contact ❒Other:_____

❒The patient/SDM has consented to messages being left at the above phone numbers.

Test Results which MUST accompany the referral:

❒ Consult notes ❒ Pulmonary Function Tests (PFTs) ❒ Electrocardiogram (ECG) ❒ ECHO
❒ Arterial blood gases (if done) ❒ Cardiology Assessment &/or Exercise Stress Test ❒ Blood work
❒ Cardiopulmonary Exercise Test (CPET) ❒ CPET Booked Date (year/month/day):_____
If CPET is not done, the referring respirologist verifies that the patient is safe to proceed with a progressive exercise program ❒

REFERRING DIAGNOSIS:	
DATE OF ONSET (year/month/day)**:**	
RELEVANT PAST MEDICAL HISTORY:	
SMOKING HISTORY (including quit date & total # pack years smoked):	
OXYGEN USE (including Flow Rate, Rest, Exertion, QHS):	

Does this person have *any current* ARO infection / isolation concerns? ❒Yes ❒No
(Please Specify): ❒MRSA ❒VRE ❒C.Diff ❒ESBL ❒Other: _____

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Driving Information *Please discuss any medical/functional concerns with the patient before submitting this referral*

Is the patient medically fit to drive? ❒Yes ❒No ❒Uncertain

Has the Ministry of Transportation been informed that the patient has a medical condition that may affect their ability to drive?
❒Yes ❒No ❒Uncertain

Medication Profile (Please list or attach the current medication list with dosages)

Allergies (describe allergic reaction)

❒ None known ❒ Drug allergies_____ ❒Food or Environmental allergies_____

Allergic reaction:

ADVANCED DIRECTIVE (please include specifics of Directive):

Transportation (How will the patient get to the WRHN @ Chicopee Pulmonary Rehabilitation Clinic?)

❒Family/Friend will drive ❒Mobility Plus/Kiwanis Transit ❒Bus or Taxi ❒ Patient will drive self

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

☐ ☐ The referral form was completed with the client/substitute decision maker, and the reason for the referral has been discussed.

Family Physician

Last Name:	First Name:	Phone #:
		Fax #:

Referring Respirologist

Last Name:	First Name:	Phone #:
		Fax #:

Physician Signature (REQUIRED)

	Billing #:	Date: (year/month/day)

Fax Completed Form (2 pages) to Fax #: 519-894-8307
Please direct any questions via phone to #: **519-894-8340**

NOTE: Please attach medication profile and all relevant reports.
All incomplete referral forms will be returned to referral source for completion