Program Referral

Caring for my COPD is a 10 week community-based pulmonary rehab program consisting of education 1x/week and exercise 2x/week.

REFERRAL DATE: ___ ___ ___ M D Y	DATE OF BIRTH: ___ ___ ___ M D Y	OHIP#

SURNAME:	FIRST NAME:	TEL:
ADDRESS:	CITY:	POSTAL CODE:

REFERRAL SOURCE	NAME:	ADDRESS:	
	TEL:	FAX:	
PRIMARY CARE PROVIDER (if different than above)	NAME:	TEL:	FAX:

Is client's COPD diagnosis confirmed by spirometry?

- ☐ Yes (please send most recent results)
- ☐ No (please refer client for spirometry and forward results onto our program when received)

Is client on supplemental oxygen?

- ☐ No
- ☐ Yes (please fill out prescription below)

Oxygen prescription: _____ **L/min at rest**
_____ **L/min on exertion**

Is client a CO2 retainer?

- ☐ Yes
- ☐ No
- ☐ Unsure

Does the client have known or suspected cardiac health concerns?

- ☐ No
- ☐ Yes, please explain: _____

Does the client have any outstanding cardiac investigations or follow-up? ☐ **YES** ☐ **NO**

PHYSICIAN or NP's CLEARANCE TO PARTICIPATE IN EXERCISE

To ensure client safety for graded levels of exercise, please indicate below if client is **medically stable and cleared to participate in mild to moderate exercise**

- ☐ YES, client is medically stable and **can participate** in exercise
- ☐ NO, client **cannot participate** in exercise

Physician / Nurse Practitioner / Delegate Signature:

***Fax signed and completed form to*: 519-754-0757**

****Please attach most recent spirometry results if available****

Ontario
Hamilton Niagara Haldimand Brant Local Health Integration Network
Réseau local d'intégration des services de santé de Hamilton Niagara Haldimand Brant