Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
Health Card #
PHIN
Age

PULMONARY REHAB PROGRAM REFERRAL FORM

PHONE: (833) 277-0202 FAX: (833) 277-0203

For Pulmonary Rehab Intake Use Only

Program Preferred: ☐ Virtual PR ☐ Community Based PR ☐ Better Breathers- Education only

DATE OF REFERRAL: |_|_|_|_|_|_|_|_|

Client has been advised of referral and agrees to attend if accepted?
(Note: Do not proceed with referral until question answered Yes) ☐ Yes ☐ No

Client Contact Information: Address: ______________________ Postal Code: __________

Phone: |_|_|_|-|_|_|_|-|_|_|_|_| Alternate Phone: |_|_|_|-|_|_|_|-|_|_|_|_|

Will client require an interpreter? ☐ Yes ☐ No If Yes, Indicate Language(s) Spoken: __________

TO ARRANGE APPOINTMENT, CALL: ☐ **Client** **or** ☐ **Primary Contact**

Primary Contact Name: ______________ Relationship: __________ Phone: |_|_|_|-|_|_|_|-|_|_|_|_|

SECTION TO BE COMPLETED BY ONE OF THE FOLLOWING:

☐ **Primary Care Provider** ☐ **NBRHC** ☐ **Respirologist**

REASON FOR REFERRAL: ☐ COPD Confirmed ☐ COPD Suspected

	Date:
☐ Recent Hospital Stay	__________
☐ Recent COPD Exacerbation	__________
☐ Recent ED Visit	__________

Currently on LABA/LAMA/ICS? ☐ Yes ☐ No Current Prescription (if known): __________

Currently on Oxygen Therapy? ☐ Yes ☐ No Current Prescription (if known): __________

Attached are the following test results completed within the past 6 months*:

☐ Pulmonary Function Tests *and/or* ☐ Spirometry ☐ Chest X-Ray

☐ ECG/Holter Monitor *and/or* ☐ Echocardiogram ☐ Respirologist Notes

** If not provided, we may facilitate any of the above tests as needed per AACVPR guidelines*

FOR REFERRAL TO PULMONARY REHABILITAITON, fax form to intake location (below) of choice :

- **North Bay Regional Health Centre Breathing Clinic (Dr. Irfan Khan)**

  FAX requisition to 705-495-8116

- **Rapid Access Respiratory Clinic (Dr. Maya De Zoysa)**

  FAX requisition to 705-479-5100

I approve of the referral to the Pulmonary Rehabilitation Program with Respirologist involvement and I feel the client is safe to begin supervised exercise:

______________________ and ______________________ Date: |_|_|_|_|_|_|_|_|

(SIGNATURE) (PRINTED NAME AND DESIGNATION) D D M M M Y Y Y Y