

PHYSICIAN REFERRAL TO **OUT-PATIENT** PULMONARY REHABILITATION **PROGRAM**

Grand River Hospital, Freeport Health Centre 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.
- Motivated to participate in an education and exercise program
- Non-smoking.
- No contraindications to cardiovascular exercise.

RESPIROLOGY ASSESSMENT IS MANDATORY BEFORE ENTRY

Family Physician Referral:

- Initiate referral form: fill in all appropriate fields.
- Send referral form to Respirologist.
- Respirologist will complete and forward the referral form.

All Waterloo Region Respirologists make referrals to the Program. If patient does not have a Respirologist, the referral process can be expedited through the Program Medical Director, Dr. Eric Hentschel.

Respirologist Referral:

- 1. Assures appropriateness / safety for Program.
- Reviews general expectations gives patient handout from Program.
- Completes all fields on the admission form, and attaches history, PFTs and ABGs relevant reports.
- 3. Completes all fields on the admission form, and attacnes nistor4. Forwards the completed form to the address or number above.

Patient Ide	entificat	ion							
Last Name]	First Name		Initi	ial	Birth date		
							(Year- Month-Day)		
Street Address	<u> </u>						(10	ai Month Buy)	
City				Prov.			Postal Code		
Home Ph #		Business ph # Health #				Sex		Marital Status	
	_								
Diagnoses:									
Medications:									
Drug Allergies	·								
Drug / mergies	•								
Shortness of Breath:	☐ At rest	☐ While dressing	☐ While dressing ☐ When wa			alking less than one block/one flight of steps			
	☐ When walking more than one block/one flight of steps ☐ During strenuous activities							trenuous activities	
Smoking history:	□ Never	Quit date:	Quit date:			Total pack-years smoked:			
Oxygen use:	□ None	Flow rate		Hours					

Test Results which must accompany referral:												
Pulmonary Function Tests	report a	ttached										
Arterial blood gases	report a	report attached □										
ECG	report a	report attached □										
Chest X-ray	report a	report attached □										
Blood work if available:												
Cardiopulmonary Exercise Test (CPET) is required before the Program												
CPET report attached □												
CPET booked (date)												
(Year –Month–Day)												
Respirologist wants Program to arrange CPET ? Yes □ No□												
Physician Information												
Referral initiated by (circle one) Family Physician Respirologist												
Family Physician:	- M		I.B. #									
Name:	Phone #	Fax #										
Address:		City		Postal Code								
Signature:		Date:										
Respirologist:	Respiratogist:											
Name:	Phone #	Fax #										
Address:		City		Postal Code								
Signature:		Date:										
Signature.		Date.										
		•										
Specific medical or other concerns to b	e addressed in the Program ((attach pages	if needed)									
Office Use: Freeport Pulmonary Rehabilitation Program												