Department of Rehabilitation Services
Phone – 519-767-3414
Fax – 519-767-4160

Patient Name:________________
DOB: ____________________
OHIP #: ___________________
Phone #: __________________
Alt Phone # _________________

Out-Patient COPD/Pulmonary Rehab Program Application

Date:______________________________

The COPD/Pulmonary Rehab program is an 8 week program consisting of exercise and education geared to teaching the client about disease self-management.
In order to complete the referral process, **please complete both sides of this form, sign, and date, then return it to us as soon as possible so that the referral can be completed. Fax to 519-767-4160.**

Please note that all clients must be followed by a respirologist involved in the program.
Please indicate which respirologist this client is being referred to or is being followed by:

❒ Dr. Hollinger (Ph. 519-837-1011, Fax 519-837-3352)
❒ Dr. Shende (Ph. 519-823-1730, Fax 519-823-9639)
❒ Dr. Nemni (Ph. 519-341-3344, Fax 519-341-4433)
❒ Other respirologist. Please specify ________________________________

Patient Care Orders

Please sign and date below for the following orders to be valid through the program:

- ✓ Application or titration of oxygen to maintain SpO2 >89% at rest and during exercise while client is in the program
- ✓ Assessment ABG's at RRT discretion (may not be required if done in past year)
- ✓ ECG prior to the start of the program and PRN while in the program
- ✓ Spirometry pre and post 4 puffs ventolin (at RRT's discretion). May not be required if done in past year.

Ordering Physician	***Respirologist***
Date: __________________________	*Date:* __________________________
Name: _________________________	*Name:* _________________________
Signature: _______________________	*Signature:* _______________________

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Medical History		
	Chronic Lung Diagonsis	Please check those that apply: ❒ COPD ❒ Chronic Bronchitis ❒ Emphysema ❒ Asthma ❒ Bronchiectasis ❒ Interstitial Lung Disease (please specify)________________________ ❒ Other
	Cardiac Conditions	❒ MI (Please Specify) ____ ❒ Dysrhythmias (Please Specify) ________________________________ ❒ CABG ❒ CHF ❒ Chest pain / Angina ❒ AAA ❒ Other ____ ____ *If yes to any of the above cardiac clearance will be required prior to the start of the program.*
	Other Medical Conditions	(Please List)

Exclusion Criteria ***(If answered "yes" to any of the following questions, client may not be appropriate for this program)***	**Yes**	**No**
Does this client have any cognitive impairment (dementia)? If so, please list.		
Does this client have any chronic conditions that are not currently stable (i.e. acute back pain, CHF, large or unstable AAA)? If so, please list.		
Is this patient a high risk for falls?		

Inclusion Criteria ***(If answered "no" to any of the following questions, client may not be appropriate for this program)***	**Yes**	**No**
Is the client motivated to attend the program for the 8 weeks required?		
Can this client walk at least 150 ft safely and independently with or without ambulatory aid ? If aid is used , please list. ❒ Walker ❒ Cane		
Can this client actively participate in the exercise program for 1 hr, two times per week?		
Will this client be able to arrange transportation to and from the program?		