

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 Respiriologist completed as it is MANDATORY before entry into the program.

Respiriologist:

- ✓ 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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: _____



WRHN

Waterloo Regional
Health Network

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 Respiriologist

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

Physician Signature (REQUIRED)

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