Program Referral

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

Would you like the COPD team to perform spirometry on client? (referral form will be sent for completion prior to booking)

☐ Yes ☐ No

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