REFERRAL FORM
PULMONARY REHABILITATION PROGRAM
Providence Care Hospital

PREFERABLY ALL PATIENTS SHOULD BE REVIEWED BY A RESPIROLOGIST PRIOR TO REFERRAL TO REHAB.
PLEASE FAX COMPLETED FORM AND ATTACHMENTS TO 613-549-1459 FOR TRIAGING BY DR. A. NEDER.

ADMISSION CRITERIA for Entry into Pulmonary Rehabilitation:

	YES	**NO**
• Respiratory disease with functional limitations and shortness of breath	[ ]	[ ]
• Optimal medical management	[ ]	[ ]
• Cardiac disease which prevents partaking in exercise - (active CAD)	[ ]	[ ]
• Significant musculoskeletal issues that preclude meaningful participation (some accommodations can be made)	[ ]	[ ]
• Quit smoking or making significant attempt to quit	[ ]	[ ]
• Motivation to participate	[ ]	[ ]
• Ability to follow instructions and adopt new behaviours (cognitively intact)	[ ]	[ ]
• Able to attend up to 3 times weekly for 6-10 weeks or 3 weeks full-time as an inpatient (accommodations can be made for patients who are unable to attend 3 times per week)	[ ]	[ ]

Name: _____
Address: _____
_____
Phone No: _____
DOB: _____
HIN: _____
Referring Physician: _____
Primary Respirologist/Nurse Practitioner: _____
Family Physician:

Primary Diagnosis: _____

MRC Score (1-5): _____

Exacerbations per Year: _____

Six Minute Walk Test <u>REQUIRED</u> and FORWARDED: Yes: [ ]

Clinical Stability (> one month since previous exacerbation): Yes: [ ] No: [ ]

Smoking History: Active or Former _____ Pack Years: _____
Supplemental Oxygen: Yes_____ No _____ O_2 Dose _____

Active Co-Morbidities: ***(Please include copies of consultation note, investigations, etc.)****

*Cardiovascular (Active ischemic heart disease)***:** Yes: [ ] No: [ ]

(Description)_____

_____

Musculoskeletal(*Problems that limit exercise training*): Yes: [ ] No: [ ]

(Description)_____

_____

*Neuropsychiatric (That influence ability to cooperate)***:** Yes: [ ] No: [ ]

(Description)_____

_____

Level of Motivation (1 – 5 max):_____

Current Medications (Inhalers):

_____

_____

_____

(**Other)**_____

_____

_____

Preference for Inpatient (Outside Kingston Catchment Area) or Outpatient Pulmonary Rehab Program: _____

Planned Lung Transplantation or Volume Reduction Surgery: _____

Recent Pulmonary Function Tests (Within Last 6 Months): ***Please include copies of previous testing results and arrange up-to-date tests if necessary.***

_____

Previous Enrolment in Pulmonary Rehabilitation Program: _____