REFERRAL FORM
PULMONARY REHABILITATION PROGRAM
Providence Care

Fax referral to 613-549-1459, attention Dr. O'Donnell

ADMISSION CRITERIA for Entry into Pulmonary Rehabilitation:

- Respiratory disease with functional limitations and shortness of breath
- Optimal medical management
- No cardiac disease which prevents partaking in exercise (most undergo Stage II exercise test at HDH)
- No 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: _____
Family Physician:

Primary Diagnosis: _____

MRC Score (1-5): _____

Exacerbations per Year: _____

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

Smoking History: Active or Former _____ Pack Years: _____

Supplemental Oxygen: Yes_____ No _____ O_2 Dose _____

Six Minute Walk Test: Yes _____ No _____

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

Musculoskeletal: _____

Neuropsychiatric: _____

Level of Motivation (1 – 5 max):_____

Current Medications (Respiratory & Other): _____

_____

_____

_____

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

Planned Lung Transplantation or Volume Reduction Surgery: _____

Recent Pulmonary Function Tests/Cardiopulmonary Exercise Testing (Within Last 6 Months):
Please include copies of previous testing results.
_____

Previous Enrolment in Pulmonary Rehabilitation Program: _____