Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
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# PULMONARY REHAB PROGRAM REFERRAL FORM

**PHONE: (204) 831-2181 FAX: (204) 940-8633**

**For Pulmonary Rehab Intake Use Only**

Client Health Record #
Client Surname
Given Name
Date of Birth Age
Gender
Health Card #
PHIN

**Program Site:** ☐ Deer Lodge Centre ☐ Misericordia Health Centre ☐ Seven Oaks Hospital - Wellness Institute

**DATE OF REFERRAL:** |_|_|_|_|_|_|_|_| D D M M M Y Y Y Y

**Client has been advised of referral and agrees to attend if accepted?**
(Note: Do not proceed with referral until question answered Yes) ☐ Yes ☐ No

**Client Contact Information:** Address: _____ Postal Code: _____

Phone: |_|_|_|-|_|_|_|-|_|_|_|_| Alternate Phone: |_|_|_|-|_|_|_|-|_|_|_|_|

Will client require an interpreter? ☐ Yes ☐ No If Yes, Indicate Language(s) Spoken: _____

**TO ARRANGE APPOINTMENT, CALL:** ☐ **Client or** ☐ **Primary Contact** (see guideline on reverse)

Primary Contact Name: _____ Relationship: _____ Phone: |_|_|_|-|_|_|_|-|_|_|_|_|

**REFERRED BY:** _____ Program/Agency: _____

Phone: |_|_|_|-|_|_|_|-|_|_|_|_| Fax: |_|_|_|-|_|_|_|-|_|_|_|_|

Name of Respirologist, if known: _____ Phone: |_|_|_| |_|_|_| |_|_|_|_| Fax: |_|_|_| |_|_|_| |_|_|_|_|

Primary Care Provider Name: _____ Phone: |_|_|_| |_|_|_| |_|_|_|_| Fax: |_|_|_| |_|_|_| |_|_|_|_|

Primary Care Provider Address: _____ Postal Code: _____

**SYMPTOMS:**
☐ Dyspnea/Short of Breath ☐ Exercise Intolerance ☐ Declining Function ☐ Other: _____

**ADDITIONAL REQUIRED INFORMATION:**
*(Please include as much as possible of the following or the referral process may take longer than anticipated)*
☐ Pulmonary Function Tests **and/or** ☐ Spirometry (completed within 5 years)
☐ Electrocardiogram **and/or** ☐ Echocardiogram (completed within 1 year)
☐ Chest X-ray (completed within 3 years)
☐ Respirologist Notes (most recent)

Past Medical History: _____

Ambulation: ☐ Independent ☐ Aides: canes/walkers ☐ Other: _____

**SECTION TO BE COMPLETED BY ONE OF THE FOLLOWING:**

☐ **Primary Care Provider** ☐ **Attending Physician** ☐ **Respirologist**

**DIAGNOSIS:** ☐ Chronic Obstructive Pulmonary Disease ☐ Chronic Obstructive Pulmonary Disease w/Asthma Component
☐ Restrictive Disease ☐ Coronary Artery Disease ☐ Pulmonary Hypertension
☐ Neuromuscular Disorder ☐ Pulmonary Fibrosis ☐ Bronchiectasis
☐ Other: _____

☐ Additional Medical Problems: _____

Is the client currently on Oxygen? ☐ Yes ☐ No Current Prescription (if known): _____

**I approve of the referral to the Pulmonary Rehabilitation Program with Respirologist involvement and I feel the client is safe to begin supervised exercise:**

_____ and _____ Date: |_|_|_|_|_|_|_|_|
(SIGNATURE) (PRINTED NAME AND DESIGNATION) D D M M M Y Y Y Y

**Fax referrals to Pulmonary Rehab Program (204) 940-8633**
**Following Assessment Retain On Facility Health Record**

# **Guideline:** Pulmonary Rehab Program Referral Form

**Purpose/Background:**

To capture a summary of client information to assist in facilitating admission to the Pulmonary Rehab Program.

**Initiation:**

Referrals to the program can only be initiated by other health care professionals, including Primary Care Providers, Attending Physicians, Respirologists, Respiratory Therapists, Nurses, Pharmacists, Social Workers, Physiotherapists and Occupational Therapists. Potential clients must have a pulmonary diagnosis and the required diagnostic testing. A Pulmonary Rehab Referral form is completed and faxed with the collateral diagnostic results to the Pulmonary Rehab Intake at (204) 940-8633. In the event the referral is not initiated by the Primary Care Provider, the Referral Source or Pulmonary Rehab Intake Coordinator will forward back to the Primary Care Provider for completion of the last section or for any missing required tests. If the Attending Physician or Respirologist initiated the referral and can provide all of the required information and diagnostic testing, sending the form to the Primary Care Provider is deemed unnecessary.

**Definitions:**

***Regional Pulmonary Rehab:*** A regional ambulatory program providing education, exercise, conditioning, and treatment as required for clients with diagnosed pulmonary diseases. The program will be offered at Deer Lodge Centre, Misericordia Health Centre and Seven Oaks General Hospital, and is supported by a team of Respirologists, Physiotherapists, Respiratory Therapists, Pharmacist, Registered Dieticians, Occupational Therapists and Social Workers. Each client is placed on a waiting list, with admission dates to the program being determined by date of referral and urgency.

**Use:**

This form provides relevant information to the Pulmonary Rehab Intake Coordinator who distributes this form by fax to the appropriate Pulmonary Rehab Team. The Pulmonary Rehabilitation Clinician will use the referral information to arrange assessment and schedule attendance at the appropriate Pulmonary Rehabilitation Program.

**Completion:**

***Program Site:*** Completed by the Pulmonary Rehab Intake Coordinator. Program site location determined by client's home or work address.

***Client Information:*** Provide current demographics to facilitate client identity and verification of previous referrals to other programs within Rehab/Geriatrics.

***Date of Referral:*** Indicate the date the client's referral was forwarded to Pulmonary Rehab Central Intake.

***Client & Primary Contact Aware of Referral:*** Check Yes to indicate that the client or primary contact understand what the Pulmonary Rehab Program is and agree to being referred for assessment and attending if accepted.

***Primary Contact:*** The person that the patient has given permission to be contacted to schedule the assessment and program start date. The Primary Contact may be a family member or other person.

***Referral Source Information:*** Complete referral source name/designation and primary care provider contact information. Indicate Respirologist contact information if known.

***Symptoms:*** Indicate all symptoms affecting the client.

***Additional Information:*** This provides required diagnostic test results, past medical history and ambulation requirements to participate in the Pulmonary Rehab Program. All diagnostic testing must be completed within the indicated time period: EKG and/or Echocardiogram - 1 year, Pulmonary Function Tests and/or Spirometry - 5 years and Chest X-ray - 3 years and most recent Respirologist Notes.

***Section to be completed by Primary Care Provider, Attending Physician or Respirologist:*** Potential clients must have a pulmonary diagnosis and the required diagnostic tests, to ensure safety during attendance at the program. Awareness and medical clearance by the Primary Care Provider, Attending Physician or Respirologist is therefore important.

***Filing/Routing:*** The Pulmonary Rehab Referral form is faxed to the appropriate Pulmonary Rehab Program Team, based on client's address. This copy of the referral form is maintained on the facility health record and at the time of closure the contents of this facility health record will be sent to, and maintained by, the site based Health Information Departments.