COPD and Pulmonary Rehabilitation Program
St. Joseph's Hospital
268 Grosvenor Street, Room B3-030
London, ON N6A 4V2

ST JOSEPH's HEALTH CARE LONDON

# COPD PROGRAM REFERRAL FORM

Please complete **all sections** and **FAX** to **COPD Intake** at **519-646-6292**

## Patient Information

*(please affix label or complete info)*:

Surname: ______________________________

Given Name: ______________________________

Date of birth: ____________ Sex: M F
(YYYY/MM/DD/)

PIN or J Number: ______________________________

Address: ______________________________

City: ____________ Postal Code: ____________

Primary Phone: ______________________________

Alternate Phone: ______________________________

## Health Care Provider Information

*(please affix label or complete info)*:

Name: (please print) ______________________________

Phone: ______________________________

Fax: ______________________________

**Signature**: ______________________________

**Date**: ______________________________

Primary Care Provider:

______________________________
*(if not the ordering HCP)*

☐ Patient has no primary care provider

## *Reason for Referral:*

☐ COPD diagnosis, assessment and management
☐ COPD post-exacerbation (ED or hospitalization) assess
☐ COPD pulmonary rehabilitation (education and exercise)

## *Help us Prioritize your Referral Request:*

Most recent hospital admission for COPD ____________.
Most recent ED visit for COPD ____________.
☐ COPD confirmed by Spirometry/PFTs? ☐ YES ☐ NO
☐ Clinically stable ☐ YES ☐ NO If no, explain:
______________________________.
☐ Active smoker in the last 6 months
#/day ________for_______ yrs.
☐ Former Smoker and quit smoking greater than 6 months.
☐ Life long non-smoker

## *Is patient assistance required for appointment:*

☐ Interpreter (language): ____________.
☐ Oxygen therapy on arrival.

## *Please attach (if unavailable on London Hospitals electronic medical record)*

☐ Current medication list
☐ Current PFT report (within 1 year)
☐ Most recent chest x-ray report (within 1 year)
☐ Most recent echocardiogram (within 1 year)
☐ Most recent medical specialist report pertaining to COPD

COPD Clinic Use Only  Priority Code: ☐ 1 ☐ 2 ☐ 3 ☐ 4  Triage by(initials): ________

Spirometry/PFT required ☐ Yes ☐No  Chest x-ray required ☐Yes ☐No  Blood work required ☐Yes ☐No

ECG required ☐Yes ☐No  Echocardiogram ☐Yes ☐No

Patient appointment date ______________ (YYYY/MM/DD/)  Faxed to referring provider: ______________ (YYYY/MM/DD/)