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

PULMONARY REHABILITATION PROGRAM REFERRAL FORM

Send via fax: **(519) 646-6292** or email: **COPDPulmonaryRehab@sjhc.london.on.ca**

ALL SECTIONS ON PAGES 1 & 2 MUST BE COMPLETED AND SIGNED TO BE TRIAGED

Patient Information			
Surname:	Given Name:	Gender: M-☐ F-☐	DOB:
OHIP # with Version Code:	Contact:		Alternate:
Address - # and Street:		City:	Postal Code:
Email:			
Alternate Contact:	Relationship to Patient:	Contact:	
MRN:	Interpreter Required: ☐ Yes ☐ No Language:	Does the patient have transportation? ☐ Yes ☐ No Does the patient have a hearing impairment? ☐ Yes ☐ No Does the patient have vision impairment? ☐ Yes ☐ No	

MANDATORY CRITERIA: Patients with a confirmed diagnosis of COPD (post bronchodilator FEV_1/FVC ratio less than 0.7) as per CTS guidelines **AND** with all known cardiac conditions controlled and stable on optimal therapy will be accepted and must meet all of the following criteria:

☐ Basic differential workup and imaging has been completed to rule out other potential dyspnea etiologies (ischemic heart disease, heart failure, arrhythmia, pulmonary hypertension, malignancy, anemia)	☐ Patient has consented and is interested in positive health behaviour change to participate knowing they will be required to find transportation to and attend a minimum of two onsite assessments initially and one onsite assessment at 3 months and at 6 months	☐ Support is not being received elsewhere (i.e. HCCSS physio, Parkwood rehabilitation or LTC or other rehabilitation programs)	☐ Patient has an email address, access to internet, a computer or tablet with webcam videoconferencing or is willing to use a loaner iPad provided by SJHC.

COPD Diagnosis:			
Date of initial COPD Diagnosis:	Initial PFT:	FEV_1/FVC: FEV_1: DLCO:	mMRC Dyspnea Scale:

Comorbid Conditions:		
☐ Heart failure ☐ Ischemic heart disease ☐ Arrhythmias (Atrial fib) ☐ Peripheral vascular disease ☐ Hypertension ☐ Diabetes ☐ Lung Cancer	☐ Obstructive Sleep Apnea ☐ CPAP ☐ BiPAP ☐ Malignancy (specify) . ☐ Pulmonary Hypertension ☐ Periodontitis & Dental Hygiene ☐ GERD ☐ Osteoporosis ☐ Anemia ☐ Polycythemia	☐ Anxiety and Depression ☐ Cognitive impairment (specify) ☐ Chronic Pain Condition (specify) ☐ Frailty ☐ Smoking (PPY) ☐ Other (specify)

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COPD Clinical Course:	
How many times has the patient been **hospitalized for AECOPD in the past year**? How many times has the patient visited the f **ER for AECOPD in the past** year? How many times has the patient had **AECOPD in the past year** ? On **Home O_2**? ☐ Yes ☐ No - If yes, amount Patient's Home Pharmacy: **Other Details**:	
Relevant Tests included if not on Cerner or Clinical Connect: ☐ PFTs ☐ Echocardiogram ☐ Holter Monitor ☐ MIBI ☐ CPET ☐ CT ☐ Chest X-Ray ☐ Other: .	
Primary Care Provider: Referring Provider Reg and OHIP Billing No.: Signature:	Contact: Contact: Date: