

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: MF
(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/)