Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

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: _____

SECTION TO BE COMPLETED BY ONE OF THE FOLLOWING:

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

REASON FOR REFERRAL:
☐ Chronic Obstructive Pulmonary Disease
☐ Chronic Obstructive Pulmonary Disease w/Asthma Component
☐ Restrictive Lung Disease
☐ Pulmonary Hypertension
☐ Pulmonary Fibrosis
☐ Bronchiectasis
☐ Other: _____

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

REQUIRED INFORMATION TO CONFIRM DIAGNOSIS:

☐ Pulmonary Function Tests **and/or** ☐ Spirometry (completed within 2 years)
☐ Electrocardiogram (completed within 1 year)
☐ Chest X-ray (completed within 3 years)
☐ Respirologist Letters (most recent if available/applicable)

Past Medical History: _____

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

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 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 and/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 Wellness Institute Seven Oaks General Hospital, and is supported by a team of Respirologists, Physiotherapists, Respiratory Therapists, Pharmacists, Registered Dietitians, 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 Aware of Referral: Check Yes to indicate that the client understands what the Pulmonary Rehab Program is and agrees 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.

Referred by: The person initiating the referral must provide their name and program/agency. Indicate the primary care provider contact information. Indicate Respirologist contact information if known.

Required 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 - 1 year, Pulmonary Function Tests and/or Spirometry - 2 years and Chest X-ray - 3 years and most recent Respirologist letters if available.

Section to be completed by Primary Care Provider, Attending Physician or Respirologist: Potential clients must have a pulmonary diagnosis and the required diagnostic tests. Awareness and medical clearance by the Primary Care Provider, Attending Physician or Respirologist is essential.

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.