

Community Pulmonary Rehabilitation Program

GP / HOSPITALIST REFERRAL FORM

Name:	Personal Health #:
Phone:	Date of Birth: yy/mm/dd
Address (include postal code):	GP: Fax: Phone Number:

DIAGNOSIS: _____

REFERRAL

If Available please send the following info:

1. Respiratory Rehab Program
 (6 week education/exercise program)

PFT or Spirometry

Respirology Consult Letter

2. Maintenance Exercise Program
 (must have completed a 6 week resp rehab program)

ABG's if FEV1 < 50%

Medications: _____

Medical History/Co Morbidities: _____

Has the patient been seen by a Respirologist in the past year?

Yes Name: _____ Date: _____
 No

PHYSICIAN SIGNATURE: _____ DATE: _____

**PLEASE FAX COMPLETED REFERRAL FORM/CONSULT
 LETTER/TEST RESULTS TO: 604-806-8839**

Questions PH: 604-806-9466