Lakeridge Health

COPD
Community Exercise Clinic

This form must be completed and signed by a Nurse Practitioner or Physician

Your signature below indicates:

- A referral to our COPD Community Exercise Clinic.
- The physical assessment will include a 6MWT, Sit to Stand, mMRC Dyspnea Scale, CAT Score. Results will be forwarded to your office and the consulting Respirologist.
- Acknowledges that you have assessed the referred client and confirm that s/he is safe to exercise in our rehabilitation program. Participants must be able to participate independently.
- We cannot accept patient who are: clinically unstable, have unmanaged infectious disease, significant cognitive disorders, or reside in a long term care setting.

Please complete all sections of the referral and attach all related consultations.			
First Name:		Last Name:	Phone:
Address:		City:	Alternate:
DOB:	M☐ F☐	Province:	Postal Code:
Family Physician:		Phone:	Fax:
Health Card Number:			
Medical History: please check all that apply			
COPD: ☐		Recent Hospitalization Date: _____	
All other lung conditions, refer to Respiratory Rehab at LHW☐ *(bronchiectasis, Interstitial Lung Disease, Chronic Asthma, Pulmonary Fibrosis, Listed for Transplant)*			
Other: ☐			
Smoking History:			
Currently Smoking: ☐ Cig/day: _____		Quit Date: ☐ _____	Tobacco ☐ Vape ☐
Years Smoked: _____		In process of quitting: ☐	Cannabis ☐ Other ☐
Home Oxygen & Target Sp02:			
Rest _____ /lpm Sp02: _____ %		Exertion: _____ /lpm Sp02: _____ %	No current prescription: ☐
Current Medications (including respiratory medicines and beta−blockers). Attach list.			
Referring Physician/NP Name **(Please print)**		Physician/NP Signature	
Billing Number:		Date:	
Office Phone Number:		Office Fax Number:	

Please fax completed form to (905) 665−2416