Carefirst Community COPD Rehabilitation Program Referral Form

TEL: 416-847-8941
FAX: 416-847-8942

☐ **Scarborough Site** Carefirst One-stop Multi-services Centre 300 Silver Star Blvd Scarborough ON M1V0G2 10am–12pm Monday, Tuesday, Friday	**Please include the following with this referral form** 1) Recent History 2) Current medication 3) Spirometry (if available) 4) Action Plan (if available)

I acknowledge that I 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 patients who are: clinically unstable, have unmanaged infectious disease, significant cognitive disorders, or reside in a LTC setting.

Patient Name: _____ ☐ Male ☐ Female
Last *First*

DOB: _____/_____/_____ **Health Card #:** _____ **Version Code:** _____
YYYY *MM* *DD*

Address: _____
Street Number *Street Name* *Unit/Apt* *City* *Postal Code*

Home Phone: _____ **Cell Phone:** _____ **Email :** _____

Language: ☐ English ☐ Cantonese ☐ Mandarin ☐ Other: _____

Medical History: please check all that apply

☐ COPD ☐ Listed for Lung Transplant ☐ Bronchiectasis
☐ Interstitial Lung Disease ☐ Chronic Asthma ☐ Pulmonary Fibrosis
☐ Cardiac: _____ ☐ Others: _____

Smoking History:

☐ Currently Smoking Pack/day: _____ How many years? _____
☐ Quit: _____ ☐ In process of cessation:

Home Oxygen:

Rest: _____ lpm Exertion: _____ lpm ☐ No current prescription

Infection Prevention:

Antibiotic Resistant Organisms: Positive? ☐Yes ☐No If yes, please indicate ☐VRE ☐ MRSA ☐CRE
Exposure? ☐Yes ☐No If yes, please indicate ☐VRE ☐ MRSA ☐CRE

Referring Healthcare Professional Information

Name: Phone:

Designation: Fax:

Signature: _____ **Date :** _____