Community COPD Management Program

Carefirst Chronic Disease Management Centre

Better Health through self-management

What is Pulmonary Rehab?

Pulmonary rehab are lifestyle change and exercise programs to help people with lung conditions to manage their shortness of breath and reduce hospitalization due to a flare-up.

How does it help me?

Although it doesn't replace medical therapy, Pulmonary Rehab can help you:

- **Manage shortness of breath** through better breathing techniques
- **Reduce flare-ups** and deterioration through better awareness and action planning
- **Improve your energy level** by building muscle strength, heart, and lung function
- **Build a social circle** of people with similar concerns as you
- **Connect to other services** that you may need

What does it involve?

The Carefirst program is a 9 weeks program, where we meet twice a week for 2 hours each time. It involves group education and discussions, as well as aerobic and resistance exercises. We will also be helping you make changes to your lifestyle and to build a home exercise habit. Please see referral form at the back for schedule. Virtual option is also available.

Who can benefit from this program?

The Carefirst program is primarily designed for patients with COPD, however you may benefit if you have any of the following:

Medication Conditions	***Risk factors:***
• COPD • Pulmonary Fibrosis • Shortness of Breath due to a lung issue	• Inactive Lifestyle

How much does it cost?

There is a $75 program fee.

How do I enrol in the program?

Please ask a medical professional to fill out the referral form at the back.

Carefirst Chronic Disease Management Centre
Community COPD Rehabilitation Program
Referral Form

T: 416-847-8941
F: 416-646-5111
E: cdmc@carefirstontario.ca

☐ **Scarborough Site**
One-stop Multi-Services Centre 2nd Floor
300 Silver Star Blvd
Scarborough ON M1V0G2
English: 10am–12pm [Tuesday, Friday]

☐

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: _____

Relevant Medical Conditions:

Smoking History:

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

Home Oxygen:

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

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.

Referring Healthcare Professional Information

Name & Title: Phone:

Address Fax:

Signature: Date:

To aid us in providing a treatment plan, please include the following reports (if available) and any other information you feel would be relevant to the care of your patient

☐ Recent Medical History ☐ Current Medication ☐ Relevant diagnostic test results
☐ Action Plan