Lakeridge Health
Ambulatory Rehabilitation Centres

Respiratory Rehabilitation Clinic
58 Rossland Rd. W., Oshawa, L1G 2V5
Tel: 905-576-8711 ext. 4346
Fax: 905-665-2416

This form must be completed and signed by a Nurse Practitioner or Physician. **Your signature below:**

1) Indicates a referral to our Respiratory Rehabilitation Clinic *and* to Lakeridge Health's Pulmonary Function Lab. Unless 6MWT and PFT results are provided with this referral, we will arrange a 6MWT and PFT, with bronchodilator response if evidence of airflow limitation. Results will be forwarded to your office and the consulting Respirologist.
2) 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 patients who are: clinically unstable; have unmanaged infectious disease, significant cognitive disorders, or reside in a LTC setting.

Is this patient currently a Lakeridge Health Inpatient? No ☐ Yes ☐ Unit ____Discharge Date? _____

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:
Allergies?		Health Card Number:	
Medical History: please check all that apply			
COPD: ☐		Listed for lung transplant: ☐	Bronchiectasis: ☐
Interstitial Lung Disease: ☐		Chronic Asthma: ☐	Other lung condition: ☐
Pulmonary Fibrosis: ☐		Other: ☐	Cardiac disease: ☐
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		
Current Medications (including respiratory medicines and beta-blockers). Attach list.			
Drug Name		Dose	Frequency

Referring Physician's Name **(Please print)**	Physician's Signature
Billing Number:	Date:
Office Phone number:	Office Fax number:

Please fax completed form to (905) 665-2416