REFERRAL
PULMONARY REHAB

Physician referral/signature required.

First Name: ______________________ Address: ______________________

Last Name: ______________________ ______________________

Gender: ☐ Male ☐ Female City: ______________________

Date of Birth: ______________________ Province: ______________________

Patient ID: ______________________ Postal Code: ______________________

H.I.N.: ______________________ Phone: ______________________

Version Code: ______________________ E-Mail: ______________________

Family Doctor: ______________________ Respirologist/Internist: ______________________

Referring Clinician	☐ Respirologist ☐ Other (specify) ______	☐ General Internist	
Point of Referral	☐ Emergency ☐ Outpatient Clinic	☐ Inpatient Unit ☐ Other (specify) ______	☐ Physicians Office
Referral Event	☐ Moderate COPD ☐ Other (specify) ______	☐ Severe COPD	☐ Pulmonary Fibrosis

Referral Event Date: ______(MM/DD/YYYY)______ Hospitalization Required: ☐ Yes ☐ No ☐ Unknown

Please fax the MOST RECENT PFT and all pertinent consultations or diagnostic tests along with the completed referral form.

CENTRALIZED REFERRAL – FAX TO: 519-257-5277

______________________ ______________________ ______(MM/DD/YYYY)______

Referring Physician (Print Clearly) Referring Physician Signature Date

For inquiries, please call the Cardiac Wellness Centre Administration at 519-257-5111 Ext. 72525