

**REFERRAL FORM**  
**PULMONARY REHABILITATION PROGRAM**  
**Providence Care**

Fax referral to 613-549-1459, attention Dr. O'Donnell

**ADMISSION CRITERIA for Entry into Pulmonary Rehabilitation:**

- Respiratory disease with functional limitations and shortness of breath
- Optimal medical management
- No cardiac disease which prevents partaking in exercise (most undergo Stage II exercise test at HDH)
- No significant musculoskeletal issues that preclude meaningful participation (Some accommodations can be made.)
- Quit smoking or making significant attempt to quit
- Motivation to participate
- Ability to follow instructions and adopt new behaviours (cognitively intact)
- Able to attend up to 3 times weekly for 6-10 weeks or 3 weeks full-time as an inpatient (Accommodations can be made for patients who are unable to attend 3 times per week.)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone No:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**HIN:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Primary Respirologist:** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_

**MRC Score (1-5):** \_\_\_\_\_

**Exacerbations per Year:** \_\_\_\_\_

**Clinical Stability** (> one month since previous exacerbation): Yes \_\_\_\_\_ No \_\_\_\_\_

**Smoking History:** Active or Former \_\_\_\_\_ Pack Years: \_\_\_\_\_

**Supplemental Oxygen:** Yes \_\_\_\_\_ No \_\_\_\_\_ O<sub>2</sub> Dose \_\_\_\_\_

**Six Minute Walk Test:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Active Co-Morbidities: (Please include copies of consultation note, investigations, etc.)**

*Cardiovascular:* \_\_\_\_\_

*Musculoskeletal:* \_\_\_\_\_

*Neuropsychiatric:* \_\_\_\_\_

**Level of Motivation (1 – 5 max):** \_\_\_\_\_

**Current Medications (Respiratory & Other):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Preference for Inpatient (Outside Kingston Catchment Area) or Outpatient Pulmonary Rehab Program:** \_\_\_\_\_

**Planned Lung Transplantation or Volume Reduction Surgery:** \_\_\_\_\_

**Recent Pulmonary Function Tests/Cardiopulmonary Exercise Testing (Within Last 6 Months):**  
*Please include copies of previous testing results.*

\_\_\_\_\_

**Previous Enrolment in Pulmonary Rehabilitation Program:** \_\_\_\_\_