ORILLIA SOLDIERS' MEMORIAL HOSPITAL
PULMONARY REHABILITATION PROGRAM

REFERRAL FORM

To refer your patient to the Pulmonary Rehabilitation Program, please complete this form and return it to the address below.

Patient: _____ Sex: _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Birthdate (D/M/Y): _____

OHIP #: _____ Physician: _____

Pulmonary Diagnosis (please check all that apply)

_____ Chronic Bronchitis _____ Bronchiectasis _____ Emphysema _____ Asthma

_____ Other _____

Cardiovascular History (please check all that apply)

_____ Myocardial Infarction Date: _____

_____ CABG Date: _____ _____ PTCA Date: _____

_____ Angina _____ CHF _____ PVD _____ CVA

_____ Dysrhythmias (specify) _____

_____ Other (Valve Disease, etc.) _____

_____ Hypertension (BP = _____/_____)

Additional Significant Medical Conditions (please check all that apply)

_____ Diabetes _____ Obesity _____ Musculoskeletal (specify) _____

_____ Other _____

Medications (Type & Dosage)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Comments/Special Concerns

_____

_____

_____

In addition to supervised exercise, the Pulmonary Rehabilitation Program may include education/discussion sessions with the following professionals: Occupational Therapist, Physiotherapist, Respiratory Therapist, Kinesiologist, Physician, Pharmacist, and Social Worker.

Physician Signature: _____ Date: _____

Mail or Fax To: Coordinator, Cardiopulmonary Rehabilitation Program
Cardio-Respiratory Department
Orillia Soldiers' Memorial Hospital
170 Colborne Street West
Orillia, Ontario
L3V 2Z3 Fax: (705) 325-3985

Program Contacts: Andrew Ford, Coordinator
Phone (705) 327-9116

Dr. David Alexander, Medical Director
Phone (705) 327-6652

OFFICE USE ONLY

Date Received: _____ Date Patient Contacted: _____