Soldiers' MEMORIAL HOSPITAL Orillia

Apply Patient Label Here with min. of Name, DOB, Health Card #

Pulmonary Rehabilitation Referral Form

*Note: Incomplete or illegible forms will be sent back requesting amendment

Patient Information:

Patient Name		
Patient DOB		
Primary Phone #		Alt. Phone #:
Health Card # (+ Version Code)		
OSMH MRN (if applicable)		

Referring Information:

Referring Physician (Family M.D/ Internist/Specialist/Nurse Practitioner)	Physician Name (print): _____ Physician Signature: _____
Office Telephone #	
Office Fax #	

Pulmonary Diagnosis/History (please check all that apply):

☐ Chronic Bronchitis ☐ Bronchiectasis ☐Emphysema ☐Asthma

☐ Other _____

Cardiovascular History (please check and comment as necessary):

MI; Date(s): _____ ☐ NSTEMI / STEMI (*circle*)

Other- see below; Date(s): _____

☐ Unstable Angina ☐ Current Angina ☐ CHF ☐ PVD ☐ Stroke

☐ Dysrhythmias (specify): _____

☐ CABG ☐ PTCA ☐ Hypertension (BP = _____/_____)

☐ Other (Valve Diseases, CAD, etc.)

Testing; Date(s): _____

☐ Pulmonary Function Test ☐ Six-minute walk Test

☐ Stress Test ☐ Other _____

Results: _____

Additional Significant Medical Conditions:

☐ Diabetes (specify) ☐ Obesity ☐ Deconditioned ☐ Arthritis (specify) ☐ Musculoskeletal (specify)

Other/Please Specify: _____

_____

_____

Medications (Type & Dosage)

☐ Nitrates ☐Beta-Blocker ☐ ASA ☐ACE Inhibitor ☐ Diuretic ☐ Calcium Channel-Blocker

☐ Other (list below)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Comments/Special Concerns:

_____

_____

_____

Mail or Fax to: Coordinator, Cardiopulmonary Rehabilitation Program
Cardiopulmonary Rehabilitation
Orillia Solders' Memorial Hospital
170 Colborne Street West
Orillia, ON L3V 2Z3

FAX: 705 325 3985

Program Contacts: Stefan Pingel, R. Kin, Coordinator
Phone (705) 327 9116

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

FOR OFFICE USE ONLY

Date Received

Date Patient Contacted