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

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)

Medications (Type & Dosage)

☐ Nitrates ☐ Beta-Blocker ☐ ASA ☐ ACE Inhibitor ☐ Diuretic ☐ Calcium Channel-Blocker ☐ Other (list below)

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

FOR OFFICE USE ONLY

Date Received ______________________________

Date Patient Contacted ______________________________