nova scotia health authority

COBEQUID PULMONARY REHABILITATION PROGRAM REFERRAL FORM

Cobequid Community Health Centre
Respiratory Services, 40 Freer Lane
Lower Sackville, Nova Scotia, B4C 0A2
Phone: 902-869-6140 Fax: 902-865-6073

Patient label
(or complete demographic details below)

Patient Name: _____ **DOB (YYYY/MM/DD):** _____

Address: _____

Phone: (Home) _____**(Work/Cell)** _____ **HCN:** _____

Smoker > 10 pack years	Yes ☐	No ☐	Left Ventricular Heart Failure	Yes ☐	No ☐
Ex-smoker > 10 pack years	Yes ☐	No ☐	Cardiac History	Yes ☐	No ☐
Stable COPD X past 4 weeks	Yes ☐	No ☐	Exercise Stress Test	Yes ☐	No ☐

Date: _____

Other Past Medical History: _____

_____

Current Medications (including respiratory medications): _____

_____

Most recent acute respiratory event/hospital admission date: _____

Does this patient have a prescription for / require nitroglycerine?	Yes ☐	No ☐
Is there any contraindication to the patient receiving salbutamol 2-4 puffs prn?	Yes ☐	No ☐
Has this patient been seen by a Respirologist?	Yes ☐	No ☐
Is this patient currently on home oxygen?	Yes ☐	No ☐
Have you discussed advanced directives with this patient?	Yes ☐	No ☐
Does this patient have a COPD Action Plan? (*if yes, please include a copy)*	Yes ☐	No ☐
Does this patient have a "**Do Not Resuscitate"** order	Yes ☐	No ☐

Special Considerations: _____

_____

Referring Physician: _____Physician Tel. #: _____

Signature: _____ Physician Fax #: _____

Please complete page 2 (Stress Test referral form)

COBEQUID PULMONARY REHABILITATION PROGRAM REFERRAL FORM

Nova Scotia Health Authority **Halifax Infirmary** **Cardiology Clinic, 3rd floor** **1769 Summer Street, Halifax** **N.S., B3H 3A7** **Cobequid Pulmonary Rehabilitation Program** **Phone: (902) 869-6140 FAX: (902) 865-6073**	Patient label *(or complete demographic details below)*

CARDIAC DIAGNOSTIC REQUISITION

Patient Identification:

X Out-Patient

Name:_____ Phone #:_____

Address:_____

DOB (YYYY/MM/DD): ____/____/____ Sex: _____ HUN: _____

Health Card #: _____Expiry Date: (YYYY/MM/DD): ____/____/___

Cardiac Exam Requested

STRESS TESTING

Rehab:

X Slow Ramp

o Regular Ramp

o Fast Ramp

o Pulmonary Rehab

o ? Symptom Limited

Clinical Information

Indicate all relevant clinical details:

COBEQUID PULMONARY REHABILITATION PROGRAM

Referring Physician: _____Physician Tel. #: _____

Signature:_____ Physician Fax #: _____