COPD Care and Education Nova Scotia
INSPIRED COPD OUTREACH PROGRAM™
REFERRAL FORM

Implementing a **N**ovel and **S**upportive Outreach **P**rogram of **I**ndividualized care for patients and families living with **RE**spiratory **D**isease

Phone: 902-717-7596	**Fax: 902-425-4191**

INSPIRED now offers two care pathways for COPD patients living in Central Zone (HRM & West Hants):

• **COPD Care and Education NS (CCE)** provides virtual self-management education, resource navigation, and support for people with **mild to moderate** COPD. Education includes managing COPD, Healthy Behaviors/Lifestyle (including Smoking Cessation), and Advance Care Planning. Program length is determined by patient needs and preference. Additional follow up provided as requested.

• **INSPIRED COPD Outreach Program™** offers community-based COPD self-management, education, resource navigation, and support to people with **moderate to advanced** COPD who are at risk for recurrent exacerbations and hospitalizations. The program spans approximately 6 months, and consists of 1-4 home visits, then phone follow up. Additional follow up is provided as requested.

A Certified Respiratory Educator (CRE) will triage including referral to local respiratory education clinics where appropriate.

A person is eligible to participate in INSPIRED/CCE if they are not in long-term or residential care and are willing to be referred.

Spirometry is required for COPD diagnosis and management. Diagnostic spirometry must be completed before starting INSPIRED/CCE. Please send spirometry or PFT with referral or complete the spirometry requisition (page 2) if the patient has not had spirometry. Spirometry requisitions must be signed by an NP /MD. If referring healthcare provider is not an NP/MD, INSPIRED/CCE will arrange for spirometry.

Patient Name or label: _____ Contact number: _____

Patient address: _____

DOB (YYYY-MM-DD): _____ HCN: _____

Referral Date (YYYY-MM-DD): _____/_____/_____

Referring provider:_____ ❑ MD ❑ NP ❑ Other Healthcare Provider: _____

Contact number: _____ ❑ Please cc correspondence to referring clinician. Fax: _____

Notes:_____

_____

_____

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Version 2, December 11th, 2024

INSPIRED SPIROMETRY REQUISITION
Tel: 902-717-7596; Fax 902-425-4191

PLEASE COMPLETE ONLY IF NEEDED (E.G. PATIENT WITHOUT PRIOR SPIROMETRY TESTING)

Patient name _____

Patient Address _____

Date of Birth _____ *Health Card #* _____

Daytime Contact Number _____

- **Children under 16 years old please refer to IWK for Spirometry**

Requesting MD/NP: _____

Date: _____

SERVICE REQUESTED

☐ Spirometry. Reason for testing: _____

A Bronchodilator will be given if obstruction present, unless otherwise indicated by the referring provider

Yes	No	
		1. Has the patient ever had a previous spirometry test?
		2. Previously treated with oral steroids?
		3. Are they currently taking puffers? If yes, please list.
		4. Is the patient a smoker? If patient ever smoked, date quit:
		5. How many exacerbations have occurred in the past year? _____ Treated by physician? (ER/GP)
		6. Diagnostics: ☐ CT ☐ chest x-ray

* Please complete all fields as required for triage.*

* Patients with obstruction on spirometry may be contacted for education pending a diagnosis of COPD.*

Comments:

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