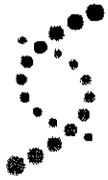

Health Sciences North
Horizon Santé-Nord

PULMONARY REHABILITATION PROGRAM

CENTRE FOR LIFE
140 DURHAM ST
SUDBURY, ON P3E 3M7
705-671-6602 / Fax 688-7301

Medical Referral / Patient Information Form

Name: Mr/Mrs/Miss ______________________________

D.O.B: ______________ (D/M/Y) H.C.#: ______________

Address: ______________________________

______________________ Postal Code: ______________

Phone: Home ______________ Work ______________

* Please include apartment and box numbers.

Pulmonary Diagnosis: ______________________________

Comorbidity: ______________________________

Shortness of Breath:
- ☐ At rest.
- ☐ With activities of daily living.
- ☐ Walking one city block.
- ☐ Walking up a slope.
- ☐ Walking one half mile.

Smoking History:

Never:

Year(s)Quit:

#Packs/Day:

☐ Pulmonary Function Test
☐ Graded Exercise Test

- ☐ Enclosed
- ☐ To Follow
- ☐ Clinic to arrange

Medications: Bronchodilators: ________ Oral: ________ Inhaled: ________

Steroids: ________ Oral: ________ Inhaled: ________

Other Medications: ______________________________

Supplemental Oxygen Dose: ______________________________

Contraindications to Exercise: ______________________________

Comments: ______________________________

____

Physician's Name: ______________________________

Phone Number: ______________________________

Physician's Signature: ______________________________

Office Use Only
Referral # ______________

Letter sent: ______________

IA ______________

____