VAUGHAN COMMUNITY HEALTH CENTRE

Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Program
Physician Referral Form

9401 Jane St, Ste. 206, Vaughan ON, L6A 4H7
Phone: 905-303-8490 ext.2 Fax: 905-303-0320

Last Name	First Name	❑M	❑F	❑Other:
Date of Birth (YYYY/MM/DD):	OHIP#: ❑ Non-Insured:			Expiry Date (MM/DD):
Address:				
Primary Phone #: Secondary Phone #:	Preferred Language:			

Preferred Method of appt: ☐ In person Visit – ☐ Mainsite (Vaughan) ☐ Keswick site
☐ Virtual Consult – ☐Telephone OR ☐Video (Ontario Telemedicine Network)

Referral Information

☐ COPD Program (Education and Exercise)
☐ COPD Exacerbation Recent: Date of hospital discharge or ED visit_____

☐ Emphysema ☐ Chronic Bronchitis ☐ Spirometry ☐ Other_____

☐ Smoking Cessation Counselling Nicotine Replacement Therapy ☐ Yes ☐ No

Recent PFT/Spirometry test reports ☐ Attached ☐ Not available

Spirometry

☐ Spirometry Request to be performed at Vaughan CHC (interpreted by Lung Specialist with report to referring MD)

☐ Yes OHIP Billing #_____ ☐ No,will interpret spirometry self and provide a copy to Vaughan CHC

Authorization to perform Pre and Post spirometry testing ☐ Yes ☐ No with ☐ Ventolin or ☐ Atorvent (Medical Directive available upon request)

Relevant History

☐ Patient Home Oxygen Therapy Flow/Level _____
☐ Psychosocial Issues _____
☐ Referral to System Navigator and other Allied Health (Social worker/Physiotherapist/Dietitian)
Comments:

Referring Healthcare Provider Information: **Name:** **Address:** **Phone:** **Fax:** **Physician Signature:** **Date:**	**Primary Health Care Provider Information (OR)** **☐Client does not have Family MD** **Name:** **Address:** **Phone:** **Fax:** **Physician Signature:** **Date:**