Caring for my COPD

North Hamilton Community Health Centre

Tel: 905 523-6611 ext. 3060
Toll Free Tel: 1-877-361-3338
Fax: 905-667-8859

Program Referral (Emphysema and / or Chronic Bronchitis)

REFERRAL DATE:	DATE OF BIRTH:	HOSPITAL DISCHARGE DATE:	GENDER:
____ ____ ____ mm dd yy	____ ____ ____ mm dd yy	____ ____ ____ mm dd yy	

Surname:	First name:	Telephone:
Address:	**City:**	**Postal code:**
Health card number:		

REFERRING PHYSICIAN / NP	Name:	Address:
	Telephone#:	Fax#:

Recent: **FEV_1** _____%	**FVC:** _____%	**FEV_1/FVC ratio**_____ %	**Date:** ____ ____ ____ mm dd yy

NOTE: the FEV1/FVC ratio must be <70%

Smoker: ☐ **YES** OR ☐ **NO**

☐ Attach patient summary if available with referral form and complete sections below if not covered in patient summary

MAJOR DIAGNOSIS/ COMORBIDITIES:		
	☐ COPD (Dx confirmed by spirometry)	☐ Stroke/TIA
	☐ Chronic Bronchitis	☐ CHF
	☐ Emphysema	☐ Previous Myocardial Infarction
	☐ Asthma	☐ Hypertension
	☐ Bronchiectasis	☐ Heart Failure
	☐ CO_2 Retainer	☐ Osteoporosis
	☐ Diabetes Mellitus	☐ Aneurysm
	☐ Other: (Please list)	

MEDICATIONS:			
	☐ Inhaled Bronchodilators	☐ Inhaled Steroids	☐ Diuretic
	☐ Oral Bronchodilators	☐ Beta Blockers	☐ Insulin
	☐ Oral Steroids	☐ Anti-anginal	☐ Anti-hypertensive
	☐ Oxygen: _____ L/min at rest _____ L/min on exertion		
	☐ CPAP/BIPAP: _____		
	☐ Other: (Please list)		

Physician or NP's Clearance to Participate in Physical Activity Stream

To ensure client safety for graded levels of exercise, please indicate below if client is **medically stable and cleared to participate in moderate physical activity** (based on self perception of exertion).

◯ Client is **medically stable** and can **participate in exercise** at this time × _____
Physician / NP signature

◯ Client is **NOT medically stable.** Should enter **education stream only** ×_____
Physician/ NP signature

If your client has any contradictions or restrictions for physical exercise, please note here:

Examples of contraindications for entry into the COPD Exercise Stream. *May not be an exhaustive list*

- Unstable angina
- Uncontrolled hypertension >160 systolic/>95 diastolic
- Significant drop (20 mmHg or +) in resting systolic BP from client's average not explained by medication
- Moderate to severe aortic stenosis
- Acute systemic illness or fever
- Uncontrolled atrial or ventricular arrhythmias
- Uncontrolled tachycardia (greater than 100bpm)
- Third degree heart block
- Active pericarditis/ myocarditis
- Recent embolism
- Thrombophlebitis
- Resting ST displacement (greater than 3mm)
- Uncontrolled diabetes
- Orthopedic problems that prohibit exercise
- Generally worsening conditions (until resolved)
- Symptomatic CHF

*If there are **any changes in your client's status** that would make them ineligible for exercise, please advise them to discontinue the exercise program and inform the COPD program staff until concern(s) is resolved.

Client may still be eligible for Education.

We will send communications to your office once the client enters the program and upon graduation. We also have the option of sending a mid-program report if you wish. **Please indicate below if you would like to receive this report:**

◯ **NO** I do not wish to receive a mid-program report at 5 weeks
◯ **YES** Please send me the mid-program report at 5 weeks

Physician / Nurse Practitioner Signature:

×

➤ ***Send signed and completed form to:***

Attention: Caring For My COPD Program,
North Hamilton Community Health Centre

Telephone: 905 523-6611ext. 3060 **Fax:** 905-667-8859 **Email:** hoyle@nhchc.ca