Department of Rehabilitation Services
Phone – 519-767-3414 Fax – 519-767-4160

Patient Name: ____________________
DOB: ____________________
OHIP #: ____________________
Phone #: ____________________
Alt Phone # ____________________

Out-Patient COPD/Pulmonary Rehab Program Application

Patient Care Orders	**Please sign and date below for the following orders to be valid through the program:** ✓ Application or titration of oxygen by RRT or PT to maintain SpO2 >88% at rest and during exercise while client is in the program ✓ Assessment ABG's at RRT discretion (may not be required if done in past year) ✓ ECG prior to the start of the program and PRN while in the program ✓ Spirometry pre and post 4 puffs salbutamol (at RRT's discretion). May not be required if done in past year.

❑ Full Pulmonary Rehab Program

Full 8 week program (16 sessions over 8 weeks) consisting of exercise (treadmill, stationary bike, UBE, weights), and education focusing on teaching the client about disease self-management.
Please note that all clients must be followed by a respirologist involved in the program. A referral will not be made by SJH.

Please indicate which respirologist this client is being referred to or is being followed by / has been referred to:

❒ Dr. V.Shende (Ph. 519-823-1730, Fx 519-823-9639) ❒ Dr. J.Nemni (Ph. 519-341-3344, Fx 519-341-4433)
❒ Dr. J. Le (Ph. 519-341-6118, Fax 519-341-6023) ❒ Other ____________________

Medical History		
	Chronic Lung Diagnosis	Please check those that apply: ❒ COPD ❒ Chronic Bronchitis ❒ Emphysema ❒ Asthma ❒ Bronchiectasis ❒ Interstitial Lung Disease (please specify)____________ ❒ Other
	Cardiac Conditions	❒ MI (Please Specify) ____________ ❒ Dysrhythmias (Please Specify) ____________ ❒ CABG ❒ CHF ❒ Chest pain / Angina ❒ AAA ❒ Other ____________ *If yes to any of the above cardiac clearance will be required prior to the start of the program.*
	Other Medical Conditions	(Please List)

Inclusion Criteria	**Exclusion Criteria**
❑ Client motivated to attend the program ❑ Client able to walk 150 feet safely and independently with or without ambulatory aid ❑ Client must be able to arrange transportation ❑ Client is able to participate in the exercise program	❑ Significant cognitive impairment ❑ Any chronic illness that is not stable (i.e. acute back pain, CHF, large or unstable AAA) ❑ High falls risk

Ordering Physician	***Respirologist***
Date: ____________	*Date:* ____________
Name (please print): ____________	*Name (please print):* ____________
Signature: ____________	*Signature:* ____________