WOODSTOCK HOSPITAL
Woodstock, ON

INTENSIVE REHABILITATION OUTPATIENT PROGRAM PULMONARY REHABILITATION REFERRAL FORM

PIN NUMBER VISIT NUMBER

PATIENT LAST NAME PATIENT 1ST NAME PATIENT MIDDLE NAME

TELEPHONE

DOB MMM DD YYYY AGE SEX ONT HEALTH CARD NUMBER

FAMILY PHYSICIAN

FOR OFFICE USE ONLY

Date received:	Date patient contacted:	Intake date:

PROGRAM CRITERIA: Pulmonary Function Test within last 6 months

CLIENT INFORMATION

Alternate contact: Phone:

Does client consent to referral? ☐ Yes ☐ No Translator required? ☐ Yes ☐ No

Name of person filling out this form: Phone: Fax:

Client currently resides at: ☐ Hospital ☐ Rehab Unit ☐ Long Term Care ☐ Community

Have referrals been made to other agencies or services? If so, please specify:

Expected Inpatient Discharge Date (if applicable):

Family Physician:	Phone:	Fax:
Referring Physician:	Phone:	Fax:

Is patient currently followed by a Respirologist ☐ Yes – Name: _____
☐ No – Patient will be referred to WH program Respirologist

REFERRAL INFORMATION

Reason for Referral: ☐ COPD ☐ Interstitial Lung Disease (ILD)

Hospitalization: History, test results related to referring diagnosis: ☐ See attached

Relevant medical history ☐ See attached

Medications and Dosages: ☐ See attached

Target SpO_2 with activity and at rest: ☐ greater than or equal to 88 % ☐ greater than or equal to 90%
☐ greater than or equal to 92% ☐ maintain between 88% and 92%

Referring Physician's Signature (required): **Date (mmm, dd, yyyy):**

FAX COMPLETED FORM TO 519–421–4258 **ANY QUESTIONS CALL: 519–421–4206**