Community Lung Health East
Intake & Referral

Community Lung Health Programs in Champlain - Referral Form

FAX TO: 613-774-7235 | Toll- Free Fax: 1-833-384-9993
Tel: 613-238-3722 | Toll-Free Tel: 1-833-338-3722

Ontario's Community Health Centres

☐ ***Urgent Referral** (*Check for Hospital Discharge, ER Visit or Recent exacerbation)

Referral Date: _____
MM / DD / YYYY

Client Stamp/Label:

Last Name: _____ First Name: _____

Health Card #: _____ DOB: _____
YYYY/MM/DD

Address: _____

Home Phone: _____ Mobile Phone: _____

Gender at Birth: ☐M ☐F Gender Identity: ☐Intersex ☐Trans Man ☐Trans Woman ☐Two-Spirit ☐Specify:
(If different from birth)

Language Interpretation Required: ☐Yes ☐No If yes, specify language: _____

Service Request: Select Services Below (services vary by location visit communitylunghealtheast.ca for more info)

☐ **COPD Education/Self-Management:**
Service locations: Lanark, Leeds, Grenville and Renfrew Counties, Ottawa, Prescott-Russell, Stormont, Dundas and Glengarry

☐ **Spirometry for COPD Screening:**
Service locations: Lanark, Leeds, Grenville and Renfrew Counties, Prescott-Russell, Stormont, Dundas and Glengarry

☐ ***Pulmonary Rehabilitation (PR):**

- Safe to Exercise in PR Program: ☐Yes ☐No

Service locations: Lanark, Leeds, Grenville and Renfrew Counties, Ottawa and Cornwall

*Pulmonary Rehabilitation Exclusion Criteria

- Non-diagnosed lung condition, not clinically stable
- FEV1 < 20%
- Unable to walk 100m (walker/cane accepted)
- Severe cardiac disease
- Disabling stroke (must be fully independent/mobile)
- Recent Embolism (PE, thrombophlebitis)
- Severe cognitive impairment
- Major physical or mental health issues that would limit participation in education, self-management and exercise class

Medical Information/Supporting Documents:

1. Medical History: ☐Attached 2. Allergies: ☐Attached 3. Medication: ☐Attached

Check Below And Include With Referral Where Applicable to Service Request (s) :

☐ Respirologist Notes	Is the Person on Oxygen? ☐Yes ☐No
☐ Pulmonary Function Test	Ambulation: ☐Independent ☐Cane/Walker ☐Other:
☐ *Spirometry (* Required for Ottawa COPD Education and PR)	Smoking Status: ☐Current Smoker ☐Ex-Smoker ☐Non-Smoker
☐ Chest X-ray	Comments:
☐ ECG (Echocardiogram)	

Referrer Information: **Referrer Stamp/Label:**

Primary Care Provider: _____

Referring MD/NP: _____ Signature: _____ Billing #: _____

Phone: _____ Fax: _____