

RESPIRATORY REHABILITATION PROGRAM REFERRAL FORM

PLEASE COMPLETE ENTIRE FORM		
Patient Information		
Last Name:	First Name:	Initial:
Address:		
City:	Province:	Postal Code:
Telephone (Home):	(Work):	
PHN:	DOB (DD/MM/YYYY)	Sex:
Family Doctor: Address: Telephone number:		Respirologist: Address: Telephone number:
Diagnosis		
Medications		
Relevant History		
Any history of:	Cardiac disease	Neurological deficits Arthritis
Referring Practitioner		Signature:
		Date:

Respiratory rehabilitation is a multidisciplinary program administered by the physiotherapy Department. Referral to the program includes referral to members of the team, including but not limited to: Physiotherapy, Respirology, Cardiology, Nutrition Sciences and Respiratory Therapy. As part of our assessment, we conduct exercise tests appropriate for people with cardiorespiratory disorders on each candidate.

Complete referral and send with PFTs, ABGs and recent Consult letter to:

Respiratory Rehabilitation Program Director
 C/O Physiotherapy Department
 St. Paul's Hospital
 1081 Burrard Street, Vancouver, B.C.

Telephone: 604-806-8115 Fax: 604-806-9143