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RESPIRATORY REHABILITATION AND LUNG HEALTH REFERRAL

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FAX to JPOCSC Central Intake (604-953-9701)

Note: FAX RESPIRATORY REHABILITATION AND LUNG HEALTH REFERRAL with this form

PATIENT INFORMATION:

Patient's Name: _____ (Last / First / Middle) **Gender:** _____

Date of Birth: ____/____/____ (DD/MM/YYYY) **PHN:** _____ **Insurance:** _____

Address: _____ (Street / City / Province / Postal Code)

Contact Method Primary: _____ **Alternate:** _____

REFERRAL INFORMATION:

Priority: ☐ **Routine** ☐ **Urgent**

Date of Referral: _____

Referring Health Care Provider:

Name: _____

Title: _____ **Source:** _____

MSP #: _____

Phone: _____ **Fax:** _____

Reason for Referral: _____

_____

Medical Reason for Urgency: _____

_____

Relevant Medical History: _____

_____

Isolation precautions ☐ **Airborne** ☐ **Contact** ☐ **Droplet** ☐ **None**

Interpreter Required ☐ **No** ☐ **Yes** **If yes, specify language** _____

Referral Clinic: Respiratory Rehabilitation and Lung Health

Has this patient been seen by a respirologist previously? ☐ **Yes** ☐ **No** **(if Yes, please attach consult)**

Respirologist seen: _____

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Regional
RESPIRATORY REHABILITATION and LUNG HEALTH REFERRAL

Patient's Full Legal Name: _____ (Last / First / Middle) **Gender:** ☐ M ☐ F

Personal Health Number: _____ **Date of Birth:** ____/____/____ (DD/MMM/YYYY)

Address: _____ (Street / City / Province / Postal Code)

Home Phone No. _____ **Alternate Phone No.** _____

Insurance Type: ☐MSP ☐WCB ☐Out-of-Province ☐Self-Pay RCMP or Armed Forces #: _____

BreatheWell at Home	**Criteria:** Within the past year (due to respiratory related concerns): • 2 ER visits with one admission • 3 ER visits • Lives within serviced area	Meditech Referral: HH / BWAH Fax: 1-855-953-4988 Phone: 1-855-412-2121	At Home
CRS - Community Respiratory Services	☐ COPD Education ☐ Tracheostomy Education	Fax: 604-514-6079 Phone: 604-514-6106	At Home
Pulmonary Rehabilitation Clinics			
iConnect Health Center New Westminster	☐ Rehabilitation Group Education & Exercise ☐ Respirologist Assessment/Treatment ☐ COPD Self-Management Education ☐ Rehab Maintenance	Fax: 604-523-8801 Phone 604-523-8800	Physician Referral Required
Ridge Meadows Hospital - Maple Ridge/Pitt Meadows	☐ Rehabilitation Group Education & Exercise ☐ COPD Self-Management Education ☐ Rehab Maintenance	Fax: 604-463-1887 Phone: 604-463-1820	Respirologist Referral Required
Jim Pattison Pavilion Outpatient Clinic Services - Surrey (English & Punjabi)	☐ Rehabilitation Group Education & Exercise ☐ COPD Self-Management Education ☐ Lung Health Clinic (Respirologist) ☐ Rehab Maintenance	Centralized Intake JPOCSC/SMH Fax: 604-953-9701 Phone: 604-953-9704	Physician Referral Required
Langley Memorial Hospital	☐ Rehabilitation Group Education & Exercise ☐ COPD Self-Management Education	Fax: 604-533-6449 Phone: 604-534-4121 Ext #: 745273	
Abbotsford Regional Hospital	☐ COPD/Asthma Self-Management Education	Fax: 604-851-4774 Phone: 604-851-4700 Ext #: 642215	
Chilliwack General Hospital	☐ Rehabilitation Group ☐ Rehab Maintenance ☐ Education & Exercise	Fax: 604-702-4709 Phone: 604-795-4141 Ext #: 614261	

Oxygen use: Rest ___ lpm / Exercise ____ lpm | **Ability to participate in a graduated exercise program?** ☐ Yes ☐ No

If no, please specify: _____

Pertinent History:

Respiratory Related Medications:

_____

_____

Other Medications:

_____

_____

Please forward copies of any of the following tests:

☐ ECG report (within 6 months) ☐ X-ray report (within 1 year)
☐ CBC & Lytes (within 3 months)
☐ PFT & ABG's (within 6 months)

For office use only:

Clinic appt: _____
Patient contacted: _____
Appt confirmed: _____

FAMILY PHYSICIAN (if different from referring source):

Name: _____
MSP #. _____
Phone: _____ Fax: _____
☐Patient has no GP/NP

REFERRING HEALTH CARE PROVIDER:

Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐GP ☐Specialist ☐NP ☐Hospitalist ☐ER ☐Other

Referring Physician Signature: _____ **Date** (dd/mmm/yyyy)**:** _____

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