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# RESPIRATORY REHABILITATION AND LUNG HEALTH REFERRAL



RTXX106256A

Rev: March 2015

Page: 1 of 1

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

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

### PATIENT INFORMATION:

Patient's Name: _____			Gender: _____
Last	First	Middle	
Date of Birth: _____ / _____ / _____	PHN: _____	Insurance: _____	
(DD/MM/YYYY)			
Address: _____			
Street	City	Province	Postal Code
Contact Method	Primary: _____	Alternate: _____	

### REFERRAL INFORMATION:

Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent Date of Referral: _____	<b>Referring Health Care Provider:</b> Name: _____ Title: _____ Source: _____ MSP #: _____ Phone: _____ Fax: _____
Reason for Referral: _____	
Medical Reason for Urgency: _____	
Relevant Medical History: _____	

Isolation precautions <input type="checkbox"/> Airborne <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> None
Interpreter Required <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify language _____
Referral Clinic: Respiratory Rehabilitation and Lung Health

Has this patient been seen by a respirologist previously? <input type="checkbox"/> Yes <input type="checkbox"/> No (if Yes, please attach consult) Respirologist seen: _____
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# RESPIRATORY REHABILITATION REFERRAL Regional



RTXX105899C

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Page: 1 of 1

<b>Patient's Full Legal Name:</b> _____ Last First Middle			<b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Personal Health Number:</b> _____		<b>Date of Birth:</b> ____/____/____ DD/MMM/YYYY	
<b>Address:</b> _____ Street City Province Postal Code			
<b>Home Phone No.</b> _____		<b>Alternate Phone No.</b> _____	
<b>Insurance Type:</b> <input type="checkbox"/> MSP <input type="checkbox"/> WCB <input type="checkbox"/> Out-of-Province <input type="checkbox"/> Self-Pay RCMP or Armed Forces #: _____			
Community Respiratory Services & BreatheWELL/COPD	<input type="checkbox"/> COPD Education <input type="checkbox"/> Tracheostomy Education	Fax: 604-514-6079 Phone: 604-514-6106	At Home
<b>Pulmonary Rehabilitation Clinics</b>			
iConnect Health Center New Westminster	<input type="checkbox"/> Rehabilitation Group Education & Exercise <input type="checkbox"/> Respiriologist Assessment/Treatment <input type="checkbox"/> COPD Self-Management Education <input type="checkbox"/> Rehab Maintenance	Fax: 604-523-8801 Phone 604-523-8800	Physician Referral Required
Ridge Meadows Hospital - Maple Ridge/Pitt Meadows	<input type="checkbox"/> Rehabilitation Group Education & Exercise <input type="checkbox"/> COPD Self-Management Education <input type="checkbox"/> Rehab Maintenance	Fax: 604-463-1887 Phone: 604-463-1820	Respirologist Referral Required
Jim Pattison Pavilion Outpatient Clinic Services - Surrey (English & Punjabi)	<input type="checkbox"/> Rehabilitation Group Education & Exercise <input type="checkbox"/> COPD Self-Management Education <input type="checkbox"/> Lung Health Clinic (Respirologist) <input type="checkbox"/> Rehab Maintenance	Centralized Intake JPOCSC/SMH Fax: 604-953-9701 Phone: 604-953-9704	Physician Referral Required
Langley Memorial Hospital	<input type="checkbox"/> Rehabilitation Group Education & Exercise <input type="checkbox"/> COPD Self-Management Education	Fax: 604-533-6449 Phone: 604-534-4121 Ext #: 745273	
Abbotsford Regional Hospital	<input type="checkbox"/> COPD/Asthma Self-Management Education	Fax: 604-851-4774 Phone: 604-851-4700 Ext #: 642215	
Chilliwack General Hospital	<input type="checkbox"/> Rehabilitation Group <input type="checkbox"/> Rehab Maintenance <input type="checkbox"/> Education & Exercise	Fax: 604-702-4709 Phone: 604-795-4141 Ext #: 614261	
Oxygen use: Rest ____ lpm / Exercise ____ lpm		<b>Ability to participate in a graduated exercise program?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please specify: _____			
Pertinent History:			
<b>Respiratory Related Medications:</b> _____ _____		<b>Other Medications:</b> _____ _____	
<b>Please forward copies of any of the following tests:</b> <input type="checkbox"/> ECG report (within 6 months) <input type="checkbox"/> X-ray report (within 1 year) <input type="checkbox"/> CBC & Lytes (within 3 months) <input type="checkbox"/> PFT & ABG's (within 6 months)		<b>For office use only:</b> Clinic appt: _____ Patient contacted: _____ Appt confirmed: _____	
<b>FAMILY PHYSICIAN</b> (if different from referring source): Name: _____ MSP #: _____ Phone: _____ Fax: _____ <input type="checkbox"/> Patient has no GP/NP		<b>REFERRING HEALTH CARE PROVIDER:</b> Name: _____ MSP #: _____ Phone: _____ Fax: _____ <input type="checkbox"/> GP <input type="checkbox"/> Specialist <input type="checkbox"/> NP <input type="checkbox"/> Hospitalist <input type="checkbox"/> ER <input type="checkbox"/> Other	

Print Shop # 263210

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