Program Referral

Tel: 519-754-0777 ext. 235
Fax: 519-754-0757

Location:

☐ **Grand River Community Health Centre**

☐ **Simcoe** ☐ **Delhi**

REFERRAL DATE: ___ ___ ___ M D Y	DATE OF BIRTH: ___ ___ ___ M D Y	GENDER: ☐ Male ☐ Female	OHIP#

SURNAME:	**FIRST NAME:**		**TEL:**
ADDRESS:	**CITY:**		**POSTAL CODE:**
REFERRING SOURCE	**NAME:**	**ADDRESS:**	
	TEL:	**FAX:**	
PRIMARY CARE PROVIDER (if different than above)	**NAME:**	**TEL:**	**FAX:**

SPIROMETRY RESULTS Date:	**FEV1:** %	**FVC:** %	**FEV1/FCV:** %

OXYGEN	_____ **L/min at rest**	_____ **L/min on exertion**	**SMOKER**	☐ **YES** ☐ **NO**

OTHER SERVICES AVAILABLE TO CLIENTS:	☐ **Occupational Therapy**	☐ **Social Work**	☐ **Dietitian**

PHYSICIAN or NP's CLEARANCE TO PARTICIPATE IN EXERCISE STREAM

To ensure client safety for graded levels of exercise, please indicate below if client is **medically stable and cleared to participate in mild/moderate exercise** (based on self perception of exertion).

☐ Client is **medically stable** and can **participate in exercise and education**

☐ Client is **NOT medically stable** and should participate in / attend **education only**

Physician / Nurse Practitioner / Delegate Signature:

Send signed and completed form to:

Caring for my COPD
Grand River Community Health Centre
Tel: 519-754-0777 ext. 235 **Fax: 519-754-0757**

***PLEASE ATTACH PATIENT SUMMARY AND SPIROMETRY REPORT IF AVAILABLE ***

Ontario
Hamilton Niagara Haldimand Brant Local Health Integration Network
Réseau local d'intégration des services de santé de Hamilton Niagara Haldimand Brant