Comox Valley Take Heart and Breathe Well Referral Form

- ☐ Participants must be medically stable and able to function in a group
- ☐ Referral should include result of Exercise Stress Test and/or Echo (within 1 year), Spirometry or PFT (within 2 years) and a list of current medications.

Fax or email completed form attention: Susan Simo FAX NUMBER: 250-941-0099 or cvcpwo@gmail.com

CLIENT INFORMATION

Last Name: _____First Name: _____DOB: (yyyy/mon/dd) _____

Address: (street, city, province, postal code)

_____

Telephone Number: _____

Alternate Telephone Number: _____

Email Address: _____

Allergies: _____

Alternate Contact Name: _____

Phone: _____

Family Physician: _____

Specialist: _____

CLIENT MEDICAL INFORMATION (COMPLETED BY PHYSICIAN)

Framingham score: _____
NYHA Functional score: _____

Pulmonary Disease
Disease Severity: _____

Comorbidities:

- ☐ Tobacco use
- ☐ Excess Weight
- ☐ Hypertension
- ☐ ETOH
- ☐ Diabetes or Pre-Diabetes
- ☐ Abnormal Lipid Levels
- ☐ Home Oxygen Therapy
- ☐ Inactivity
- ☐ Anxiety / Depression

Secondary/ Other Diagnosis: _____

Activity Limiting Factors or Contraindications: _____

Clients will be given an individualized exercise program based on initial assessment (previous functional stress test to prescribe target heart rates) and/or 6 minute walk test and rating of perceived exertion. Exercise prescription by a Certified Exercise Physiologist will include all or some of the following: cardiovascular exercise, resistance training, balance and functional training and stretching, unless limitations are suggested above.

Referring Physician Name: _____Physician Signature: _____Date: _____

CLIENT RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize release of my medical records to the Comox Valley Take Heart and Breathe Well Program by my Physician or Hospital.

Patient Name: _____ Patient Signature: _____