



## 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 [cvcppo@gmail.com](mailto:cvcppo@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: \_\_\_\_\_ Pulmonary Disease  
NYHA Functional score: \_\_\_\_\_ Disease Severity: \_\_\_\_\_

#### Comorbidities:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Tobacco use   | <input type="checkbox"/> ETOH                     | <input type="checkbox"/> Home Oxygen Therapy  |
| <input type="checkbox"/> Excess Weight | <input type="checkbox"/> Diabetes or Pre-Diabetes | <input type="checkbox"/> Inactivity           |
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Abnormal Lipid Levels    | <input type="checkbox"/> 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: \_\_\_\_\_