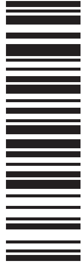
ST JOHN OF GOD
Geelong Hospital



G0-80

OUTPATIENT PULMONARY REHABILITATION REFERRAL

U.R. Number ....

Surname ....

Given Names ....

Date of Birth ...... / ...... / ...... Sex ......

Use Label If Available or BLOCK LETTERS

Contact Details

Patient	GP
Patient Name:	GP Name:
Address:	GP Clinic/Address:
Postcode:	
DOB:	
Patient Phone:	GP Phone:

Inclusion Criteria

- ☐ Has a diagnosis of stable chronic lung disease COPD or ILD
- ☐ Breathlessness that limits functional ability, secondary to a respiratory cause
- ☐ Current Pulmonary function test, if applicable, is attached to this referral
- ☐ BP no greater than 170/100 but ideally less than 150/90
- ☐ HR stable; no untreated arrhythmias or new tachycardia
- ☐ Medically stable and optimised medication
- ☐ Cardiovasculary stable
- ☐ Able to follow simple commands in a group environment
- ☐ Pulmonary rehabilitation discussed & client motivated and willing to attend an 8-week program

Tick to confirm patient meets ALL of the listed inclusion criteria

Clinical Details

Primary respiratory diagnosis			If COPD: GOLD system ***Please attach spirometry results*** ☐ **Mild**: FEV1 ≥80% predicted ☐ **Mod**: 50% ≤ FEV1 <80% predicted ☐ **Severe**: 30% ≤ FEV1 <50% predicted ☐ **Very severe**: FEV1 <30% predicted	
Past Medical History				
Smoking history	☐ Never smoked	☐ Ex-smoker When:	☐ Smoker Prepared to quit? Y / N	Pack year history:
Oxygen Saturations	Room air: %		On O_2 _____ LPM %	
	Ambulatory: %		Other: %	
Supplementary oxygen	Has home O_2 Y / N		LTOT (>15 hrs/day) ____ LPM	
Medications	Respiratory ☐ Beta Agonist ☐ Anti-cholinergic ☐ Oral Steroid	☐ LAMA ☐ LABA ☐ ICS	Other:	
Any other relevant information				

Referrer

Name		Signature Date
Role ☐ GP ☐ Primary HCP ☐ Resp. medical team	☐ Resp. HCP ☐ Non-resp. medical team Other ________	Email address Contact number

Please submit by fax to: 5226 1343

NO WRITING IN MARGINS

SGHGGFMRG080 06/17

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