COPD ConnEx

PF ConnEx

PATIENT REFERRAL FORM

This 10-week remote, home-based exercise and education program leading to better self-management.

Patient Information

Full Name: _____

Date of birth (M/D/Y): _____

Phone number: _____

Primary Disease/Condition:

_____

Physician Information

Name: _____

Clinic/Hospital: _____

Tel. #: _____

E-mail: _____

Fax: _____

FEV1 : _____ **FVC :** _____ **Date performed (if available):** _____

Oxygen (if applicable): _____ L/min

Co-morbidities: (Check all that apply)

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Diabetes
- ☐ Obesity
- ☐ Stroke
- ☐ Cancer
- ☐ Other: _____

Additional comments:

_____

_____

_____

To ensure patient safety for exercise, please indicate if patient is medically stable and cleared to participate in mild/moderate exercise:

- ◯ Client is **medically stable** and can **participate in exercise and education program**
- ◯ Client is **NOT medically stable**

I would like to be updated on my patients progress:

- ◯ Yes Preferred method of contact : ◯ Email ◯ Phone
- ◯ No

Signature: _____ Referral Date: _____