Caring for my COPD

COMPASS COMMUNITY HEALTH

Tel: 905 523 6611 x 3060
Fax: 905 667 8859

Program Referral

COMPASS Community Health
438 Hughson St. N., Hamilton, ON

REFERRAL DATE: ___ ___ ___ M D Y	DATE OF BIRTH: ___ ___ ___ M D Y	GENDER:	OHIP#
NAME:			TELEPHONE:
ADDRESS:	CITY:		POSTAL CODE:

REFERRING PHYSICIAN / NP	NAME:	ADDRESS:
	TELEPHONE:	FAX:

PRIMARY CARE PROVIDER If different from above	NAME:	TELEPHONE:	FAX:

☐ **SPIROMETRY: MUST BE INCLUDED WITH THE REFERRAL. NOTE: The FEV1/FVC % must be < 0.7**

FEV_1:	FVC:	FEV_1/FVC %	DATE:

OXYGEN	L/min AT REST	L/min FOR EXERCISE

☐ **Patient EMR Summary must be included with referral.**

☐ **PHYSICIAN or NP's CLEARANCE TO PARTICIPATE IN EXERCISE PROGRAM must be included with referral.**

Please indicate if client is medically stable and cleared to participate in mild/moderate exercise

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

☐ Client is **NOT medically stable** and can attend **education only**

Physician / Nurse Practitioner Signature: _____

***Fax signed and completed form to*: 905 667 8859**

Referral will be triaged and INCOMPLETE referrals will be returned.

Client will be contacted for participation once completed referral is received.