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

PHYSICIAN or NP's CLEARANCE TO PARTICIPATE IN EXERCISE PROGRAM

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**

PLEASE ATTACH PATIENT EMR SUMMARY AND SPIROMETRY REPORT IF AVAILABLE

Referral will be triaged and INCOMPLETE referrals will be returned.

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